MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93-d

06718

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Balto. Co.

County THE SHEPPARD & ENOCH PRATT HOSPITAL

City or town TOWSON, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Nov-6-1941

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 years 9 months 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County

City or town Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Jackson Street

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Donald Lee Aitcheson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	no	single

6.(b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) March 16-1878 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
67	4	13	..... hrs. ..... min.

9. Birthplace Alexandria Virginia (Town, county, and state)

10. Usual occupation retired machinist

11. Industry or business

FATHER 12. Name Peter Aitcheson

13. Birthplace Maryland

MOTHER 14. Maiden name Mary E. McKeever

15. Birthplace Scotland.

16. Informant Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 31, 1945 (month) (day) (year)

Cemetery or crematory

Location Alexandria, Va.

18. Funeral director J. S. Emily

Address 809 King St. Alex. Va.

19. July 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 29 - 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November - 6 - 1941 to July - 29 - 1945 and that I last saw him alive on July - 28 - 1945

Immediate cause of death	DURATION
Acute myocardial failure	
Due to chronic myocarditis	unknown
Due to coronary sclerosis	unknown
Other conditions Involutional melancholia with arteriosclerosis	3 y 10 m.

(Include pregnancy within 3 months of death) Hospital record 18 months

Major findings of operations

Date of op.

Autopsy results confirms above statement.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur K. Pattrell, M. D. M. D. or other

Address Sheppard-Pratt Hospital Date signed


RECEIVED
AUG 9 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

06719 ★ Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Ridgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County: Baltimore
City or town: Ridgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Samuel C. Andrew

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m.	W.	Widowed

6.(b) Name of husband or wife: Olie Rebecca (nee Jones)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1855

8. AGE:

Years	Months	Days	If less than one day
90	3		..... hrs. ..... min.

8. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business

FATHER
12. Name: Wm. H. Andrew
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Sarah A. Nash
15. Birthplace: Poughkeepsie, N.Y.

16. Informant: G. Clyde Andrew
Address: Ridgewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1945 (month) (day) (year)
Cemetery or crematory: Camp Chapel
Location: Balto. Co., Md.

18. Funeral director: Sandus M. Brooks
Address: Govans, Md.

19. July 2 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 44 to June 30 45
and that I last saw him alive on June 30 1945

Immediate cause of death	DURATION
Carcinoma (Prostate)	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hunt Kelly Jr. M. D. or other
Address: Towson-Md. Date signed 7/2/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

06720

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Albright Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Albright Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Albert J. Barrett (Albert Thomas Barrett)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife: Rachael G. Barrett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2/27/1872

8. AGE: Years	Months	Days	If less than one day
73	4	23	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: American Meter Co.

FATHER
12. Name: James W. Barrett
13. Birthplace: Ireland

MOTHER
14. Maiden name: Isabella McDonel
15. Birthplace: New Orleans, La.

16. Informant: Miss Isabel Barrett
Address: 1340 N. State Pkwy., Chicago, Ill.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/21/45 (month) (day) (year)
Cemetery or crematory: St. John's Cem.
Location: Waverly, Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 7/24 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945 at 8:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-28 '45 19 to 7-19 1945 and that I last saw him alive on 7-19 1945

Immediate cause of death	DURATION
Coronary Thrombosis	27 hrs
Femoral Thrombosis	8 hrs
Due to	
Due to	
Other conditions: Parkinsons Disease	6 mo.
arthritis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M. D. M. D. or other
Address: Reisterstown, Md. Date signed: 7-20-45

Evidence for change of year of birth of deceased is shown on FILM No. G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

8

06721

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
N. York Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2121 N. Howard St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph ~~Charles~~ Franklin Barrett (or Chas Barrett) **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ida Barrett
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 5 1885 1884

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Harford Co., Md (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: College
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Harford Co. Md
MOTHER 14. Maiden name: Catherine Turner
MOTHER 15. Birthplace: Harford Co Md
16. Informant: Ida Barrett
Address: York Road - Towson, Md
17. ✓ (Burial, cremation, or removal. Which?) Date thereof 8-3-45 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson, Balto Co. Md
18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave, Balto Md
19. 8 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1945, at 5 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Cerebral hemorrhage, left.	Terminal
Due to: Epilepsy; grand mal, convulsions	7/30/45
Due to: Diabetes Mellitus	Unk.
Other conditions: Hypertensive, cardio-vascular disease with myocardial insufficiency	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: Rollin E. Hudson MD D.M.D.
M. D. or other
Address: Towson 4, Md Date signed 7/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-4)

CERTIFICATE OF DEATH

06722

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Balto.
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3203 Putty Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothea J. Beckman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: John Beckman
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 9-1895

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace: Balto Co. (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business
FATHER 12. Name: Andrew Miller
13. Birthplace: Md
MOTHER 14. Maiden name: Anna Riley
15. Birthplace: Md
16. Informant: Family
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto
18. Funeral director: Leonard J Keech.
Address: 5305 Harford Rd.
19. 7/30 1945 Leo Keech D.F.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1945, at 10 40 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to July 26 1945 and that I last saw h... alive on July 24, 1945

Immediate cause of death	DURATION
Retroperitoneal sarcoma	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold A. Groth, M.D. (M. D. or other)
Address: 8100 Harford Rd Date signed: 7/30/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06723

Reg. Dist. No. 491 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Oella
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Oella
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Oella Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3.(a) FULL NAME: Baby Boy Berry

3.(b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace: Oella, Md
(Town, county, and state)

10. Usual occupation: X

11. Industry or business: X

FATHER
12. Name: Claude Berry
13. Birthplace: Elkton, Va

MOTHER
14. Maiden name: Ruby Dean
15. Birthplace: Elkton, Va

16. Informant: Claude Berry
Address: Oella, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-45 (month) (day) (year)
Cemetery or crematory: Good Shepherd
Location: Rockland

18. Funeral director: J. G. Kaelbleman
Address: Ellicott City, Md

19. July 25, 1945 (Date rec'd by registrar) John B. Laughman, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 24 1945, to July 24 1945
and that I last saw him alive on July 24 1945

Immediate cause of death	DURATION
Asphyxiation (Hanging)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Kenneth Laughman, Unit
M. D. or other
Address: Ellicott City, Md Date signed: 7/24/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06724 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2) BL

CERTIFICATE OF DEATH

Reg. Dist. No. .....

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, institution, or street address where death occurred:
Haarlem Lodge Sanitarium
How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 433 Kenneth Square
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME Nellie WARREN Birdsong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov - 9 - 1874

8. AGE:

Years	Months	Days	If less than one day
70	8	20	..... hrs. ..... min.

9. Birthplace: Richmond - Virginia
(Town, county, and state)

10. Usual occupation: Normal School Teacher (Retired)

11. Industry or business: State of Md. Normal School

FATHER
12. Name: Capt. Merritt A Birdsong
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Quarles RAINE
15. Birthplace: Virginia

16. Informant: Mr. Fred Bingley
Address: 6408 Sycamore Road - Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 - 1 - 1945 (month) (day) (year)
Cemetery or crematory: Hollywood Cemetery
Location: Richmond, Virginia

18. Funeral director: STEWART & MOWEN COMPANY
Address: (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19. 7/31/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 29 1945, at 3:12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1945, to July 29 1945
and that I last saw h.e.v. alive on July 29th 1945

Immediate cause of death	DURATION
Coronary Occlusion	14 days.
Due to: Chronic myocarditis	2.
Due to:	
Other conditions: Generalized arteriosclerosis	2.
Agitated Depression	5 mos

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arthur V. Nicholas M.D. M. D. or other
Address: Haarlem Lodge Catonsville, Md. Date signed 7-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06725

Reg. Diat. No. 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Balt Co

City or town: Lansdowne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: Street 3111 Hammonds Ferry Rd. Lansdowne Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto. Co.

City or town: Lansdowne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John H. Blakeley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14 - 1862

8. AGE: Years: 83 | Months: 3 | Days: ✓ | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Louis Blakeley

13. Birthplace: Md.

MOTHER

14. Maiden name: Anna Snavely

15. Birthplace: Md.

16. Informant: Melvin E. Bealle

Address: 3111 Hammonds Ferry Rd. Lansdowne

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10-45 (month) (day) (year)

Cemetery or crematory: Perry Hall Cem

Location: Perry Hall Md.

18. Funeral director: Clarence E. Authen

Address: Fork Md.

19. July 11 1945 (Date rec'd by registrar) G. Kieffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945, at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to July 8 1945 and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	1 hr.
Due to: Emaciation	1 yr.
Due to: Hypertension	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Eagles, M. D. M. D. or other

Address: Reisterstown, Md. Date signed: 7-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-d)

CERTIFICATE OF DEATH

06726 P

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County BALTIMORE
City or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County BALTIMORE
City or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2457 FAIRWAY
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME PETER J. BOROWSKI

3. (b) Social Security Number 217-01-8761

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 15 1882

8. AGE: Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace POLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business CROWN CORK & SEAL

FATHER
12. Name MATTHEW BOROWSKI
13. Birthplace POLAND

MOTHER
14. Maiden name MARYANNA ? SOBUS
15. Birthplace POLAND

16. Informant MRS. CECELIA NIETUBICZ
Address 2457 FAIRWAY DUNDALK

17. BURIAL Date thereof 8-2-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ST. STANISLAUS
Location BALTIMORE, Md.

18. Funeral director George A. Weber
Address 705 S. Ann st

19. 7/30 19 45 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 19 45 at 2 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 45 to July 30 19 45
and that I last saw h.. alive on July 30 19 45

Immediate cause of death	DURATION
Acute Edema of Lungs	
Due to: Chronic Myocarditis	
Due to: Duration: Unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Gregory Zeller, M.D.
M. D. or other
Address 2739 Eastern Ave Date signed 7/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24a)

CERTIFICATE OF DEATH

06727

★ Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Clifman Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Clifman Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lily Blanche Bonis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife: Rojer Bonis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 4 1871

8. AGE:

Years	Months	Days	If less than one day
73	10	14	..... hrs. ..... min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Edwin DeClaire

13. Birthplace: Carroll Co. Md

MOTHER — 14. Maiden name: Catherine Hitchcock

15. Birthplace: Carroll Co. Md

16. Informant: Mrs. Fota Simmons

Address: Randallstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/21/45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pennsylvania

19. 7/19/45 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1945, to July 18, 1945, and that I last saw h.. alive on July 18, 1945.

Immediate cause of death	DURATION
Coronary thrombosis	5 hours
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Md. Date signed: 7/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

C6728

Reg. Dist. No. 53

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Elizabeth H. Bowles

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Herbert B Bowles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1877

8. AGE: Years	Months	Days	If less than one day
67	8	6	..... hrs. ..... min.

9. Birthplace Stitz Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Daniel Burkholder

13. Birthplace Stitz Pa.

MOTHER

14. Maiden name Anna Hartzler

15. Birthplace Pa.

16. Informant Martha L Burkholder

Address 227 E. Frederick St Lancaster Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25-45 (month) (day) (year)

Cemetery or crematory West Laurel Hill

Location Philadelphia Pa.

18. Funeral director J. F. Elms-Sons

Address Reisterstown Md.

19. July 24 1945 Mary B Elms Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-11 1938, to 7-21 1945

and that I last saw her alive on 7-21 1945

Immediate cause of death	DURATION
Coronary Occlusion	10 min
Auricular Fibrillation	7 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None, Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or other

Address Reisterstown, Md. Date signed 7-22-'45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06729

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 7 months, 17 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 years, 7 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 S. Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war - -

3.(a) FULL NAME
Mary Brown

3.(b) Social Security Number
--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife George Brown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 8, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	18	..... hrs. ..... min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual occupation none
11. Industry or business --

FATHER
12. Name Michael Warren
13. Birthplace Ireland

MOTHER
14. Maiden name Margaret Murrary
15. Birthplace Ireland

16. Informant Hospital records
Address Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 30 43 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore Md.
18. Funeral director Wm. Cook Inc.
Address 1217 St Paul St

19. 7/30 19 43 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 1942 to July 26, 1945 and that I last saw her alive on July 26, 1945

Immediate cause of death	DURATION
Terminal broncho pneumonia	2 days
Due to Chronic myocardial insufficiency with arteriosclerotic cardiovascular disease	Indef.
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address Baltimore - 28, Maryland Date signed 7/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

★ 06730 Reg. Dist. No. 38

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

(M) (I)

1. PLACE OF DEATH:
County: Balto.
City or town: Baynesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
1741 E. Joppa Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Baynesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1741 E. Joppa Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harold C. Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine M. Carter
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 24th 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	9	29		

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business: Hauling
FATHER 12. Name: Dennis Carter
13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Jane Bayne
15. Birthplace: Balto. Co. Md.
16. Informant: Mrs. H. C. Carter
Address: 1741 E. Joppa Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 (month) 26 (day) 45 (year)
Cemetery or crematory: Moreland Memorial Park
Location: Balto. Md.
18. Funeral director: Lasasalm Funeral Home
Address: 7401 Belair Rd
19. July 24th 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23rd 1945, at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1925 to July 23, 1945
and that I last saw him alive on July 22 1945

Immediate cause of death	DURATION
Neoplasm Carcinoma left lung, bronchogenic	10 mo.
Cachexia	2 Mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma left bronchus, lung, and Mediastinum Date of op. Nov. 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Rollin B. Hudson M.D.
M. D. or other
Address: Towson 4 Md. Date signed: 7/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06731 P

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wakes Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leonard W. Chrusniak

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josephine
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 15 1902

8. AGE: Years: 42 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business

FATHER
12. Name: Harry Lebrusniake
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Eva Szymanske
15. Birthplace: Baltimore

16. Informant: Josephine Lebrusniake
Address: 3110 Fleet St

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9/45 (month) (day) (year)
Cemetery or crematory: St Stanislaus
Location: Dundalk Ave

18. Funeral director: John C. Moran
Address: 3000 E Baltimore St

19. 7-6 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 + 1945, at 9.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-30-1945, to 7-4-1945 and that I last saw him alive on June 24 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	15 Minutes
Due to: arterio-sclerotic Heart Disease	3 months
Due to: Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. J. Davidow M. D. or other
Address: 3218 Eastern ave Date signed

Evidence for change of age is shown on FILM G96 JUL 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-D)

CERTIFICATE OF DEATH ★

06732

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 2514 Yorkaway
How long in hospital or institution? 10 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Pa. County:
City or town: Tower City. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: Margaret Collins.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widow

6.(b) Name of husband or wife: James R.
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 28 1878

8. AGE: Years	Months	Days	If less than one day
66 67	9	4	____ hrs. ____ min.

9. Birthplace: Switzerland. (Town, county, and state)
10. Usual occupation: Typist
11. Industry or business
12. Name of FATHER: John Andregg.
13. Birthplace of FATHER: Switzerland.
14. Maiden name of MOTHER: Hannah
15. Birthplace of MOTHER: Switzerland.
16. Informant: John S. Collins
Address: 2514 Yorkaway, Dundalk
17. (Burial, cremation, or removal. Which?) removal Date thereof 7-7-45 (month) (day) (year)
Cemetery or crematory: United Brethren Cem.
Location: Orrtanna, Pa.
18. Funeral director: Driesbach Bros.
Address: Tower City, Pa.
19. 7/3/45 19__ D M Lawrence Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 19 45, at 4 35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 45, to July 3 19 45
and that I last saw h__ alive on July 3 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 year
Due to: Hypertensive Cardiovascular disease	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R.G. S R Lindsay, M.D. M. D. or other
Address: 520 D St. Sp Hg Md. Date signed 7-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 06733 4

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Westgate Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CHARLES BARNES COMEGYS

3.(b) Social Security Number: 215-07-8307

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-5-88

8. AGE: Years	Months	Days	If less than one day
57	2	1	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Clerical Work

11. Industry or business

FATHER
12. Name: Chas L. Comegys
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Wharton
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: G. Howard E. Strong
Address: 3207 W. North Ave., Balto., Md.

19. 7-7 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1945 to July 5, 1945 and that I last saw him alive on July 5, 1945

Immediate cause of death	DURATION
UREMIA	2-1/2 wks
Due to: Chronic Nephritis	Several Years
Due to:	
Other conditions: Infection of scalp	6 wks.
Hypertension, arterial	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT.COL., M.C. M.O.R.C. U.S.A.

Address: Fort Howard, Maryland Date signed: 7-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Colb. Co.

(a) Baltimore City, Maryland

(b) Street address Lois Spring & Soller's Point Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1701 Pumphrey St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country ✓

3 (a) FULL NAME Calvin R. Crawford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 - 1916

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace N. Va.

(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Twin City Supply Co.

FATHER

12. Name Hilary R. Crawford

13. Birthplace N. Va.

MOTHER

14. Maiden Name Fey Ellie Bailey

15. Birthplace N. Va.

16 (a) Informant Mary Crawford

(b) Address 54 Sherman St. Peabody, Mass.

17 (a) Trans. (Burial, cremation, or removal) (b) Date thereof July 22 - 45 (month) (day) (year)

(c) Cemetery or crematory

Location Spencer, W. Virginia

18 (a) Funeral director John G. Connelly

(b) Address 418 Eastern Ave. Essex

19 (a) July 19 - 45 (Date filed by registrar) (b) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Pending at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.

Medical Examiner.

Date signed July 19 1945

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

CERTIFICATE OF DEATH ★

B2 C6734

Reg. Dist. No. 32

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING (2)

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 26 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 8 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2025 W. Pratt Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Estella Cyford

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert Cyford
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): June 8, 1914

8. AGE: Years	Months	Days	If less than one day
31	1	10	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Miller
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary Morressett
15. Birthplace: Baltimore, Md.

16. Informant: Estella Cyford
Address: 2025 W. Pratt St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: Geo. L. Schwab
Address: 2101 Frederick Ave., Balto., Md.

19. July 18 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945, at 8:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 1944, to July 18, 1945, and that I last saw her alive on July 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Diabetes Mellitus	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 7/18/45

Rec'd by Dr E E Nichols - 7-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06735 P

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: South Rd near Summit av
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Raspeburg P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. South Rd near Summit av
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Conrad A Deppert.

3.(b) Social Security Number 216-01-2933

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Dora.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 26 1891

8. AGE: Years	Months	Days	If less than one day
53	9	6	hrs. min.

9. Birthplace: Baltimore City. (Town, county, and state)
10. Usual occupation: machinist.
11. Industry or business: Retired since illness.
FATHER 12. Name: Joseph Anthony Deppert
13. Birthplace: ? ?
MOTHER 14. Maiden name: ?
15. Birthplace: ?
16. Informant: (Brother)
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 45 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor Ave
18. Funeral director: Martin W.G. Deppert Sr.
Address: 7110 Belair Rd
19. Aug. 2 19 45 A.W. Kedrick Registrar
(Date received by registrar)
A.E.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 45, at A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Several hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M Learning M.D.
M. D. or other
Address: Deputy medical exam Baltimore, Md. Date signed 8/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

06736

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 108 Osborne Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ida Virginia Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Waldie E. Dorsey
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 7, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	23	hrs. min.

9. Birthplace: Howard Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. FATHER Name: William F. Stembler
13. FATHER Birthplace: Maryland
14. MOTHER Maiden name: Angeline Warfield
15. MOTHER Birthplace: Howard Co. Md
16. Informant: Waldie E. Dorsey
Address: 108 Osborne Ave Catonsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 1945 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Elkridge City, Md.
18. Funeral director: Easton Sons
Address: 608 Frederick Ave Baltimore Md
19. July 31st 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-30 19 45, at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 19 40 to July 30 19 45 and that I last saw h.. alive on July 26 19 45

Immediate cause of death	DURATION
Cardiac Failure	24 hrs
Due to: Myocardial Degeneration	6 mo
Due to: Nephritis	6 mo
Other conditions: Diabetes	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. V. Cullen MD M. D. or other
Address: 803 2nd Ave Catonsville 28 Md. Date signed: 7-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06737 P.

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 5 months, 28 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 years, 5 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5607 Roland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George Douglas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	26	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business: None
FATHER 12. Name: James Douglas
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Jane Haynie
MOTHER 15. Birthplace: Maryland
18. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Ave
18. Funeral director: John F. Denny, Inc
Address: 715 Light St
19. July 31 1945 (Date rec'd by registrar) C. W. Kodrick A.F.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1945 at 5:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1942 to July 31 1945 and that I last saw him alive on July 31 1945

Immediate cause of death	DURATION
Terminal broncho pneumonia	48 hours
Due to: Chronic arteriosclerotic myocardial disease	Indefinite
Due to: Cerebral thrombosis	3 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 7/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

6738

Reg. Dist. No. 44

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 38 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 S. Duncan Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: DENNIS C. DRISCOLL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ///// Josephine E. Driscoll

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): June 6, 1906

8. AGE:

Years	Months	Days	If less than one day
39	1	7	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business:

FATHER — 12. Name: John Edward Driscoll

13. Birthplace: Mass.

MOTHER — 14. Maiden name: Bruce Tiptom

15. Birthplace: Front Royal, Va.

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18-45 (month) (day) (year)

Cemetery or crematory: New National

Location: Frederick Rd.

18. Funeral director: John A. Moran

Address: 300 E. Balto. St.

19. 7/16 1945 (Date rec'd by registrar) H. A. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1945 to July 14, 1945

and that I last saw him alive on July 14, 1945

Immediate cause of death	DURATION
Carcinoma bronchogenic with Metastasis	Unknown
Due to	
Due to	
Other conditions: Atelectasis rt. lung	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL., M.C., Chief of Clin. Dir.

Address: Ft. Howard, Md. Date signed 7-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06729

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1116 Stockton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: GEORGE W. EASLEY

3. (b) Social Security Number: 217-09-1511

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Clara Easley
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): 5-10-82

8. AGE: Years	Months	Days	If less than one day
63	2	1	.....hrs. .....min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Banister Easley
13. Birthplace: Virginia ?

MOTHER
14. Maiden name: Rosa Martin
15. Birthplace: Virginia

18. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: John M. Johnson
Address: 1700 Druid Hill Ave., Balto., Md.

19. 7-14-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945 19..... at 8:20P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1945 to July 11, 1945 and that I last saw him alive on July 11, 1945

Immediate cause of death	DURATION
Acute pancreatitis with abscess	Unknown
of the lesser peritoneal cavity	
Due to	
Due to	
Other conditions: Lobar pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations Date of op. .....
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

SIGNATURE: A.M. Salter
A.M. SALTER, LT. COL., M.C. M.C., U.S.A.R.
Address: Ft. Howard, Md. Date signed: 7-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06740

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Baltimore
City or town Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 805 Kingston Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
William M. Eleder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura S. Eleder (nee Zick)
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 6, 1894.

8. AGE: Years	Months	Days	If less than one day
51	5	9	hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name James J. Eleder
FATHER 13. Birthplace Balto. Md.
MOTHER 14. Maiden name Mary Kudernur
MOTHER 15. Birthplace Austria
16. Informant Mrs. Laura S. Eleder
Address 805 Kingston Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/45 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18. Funeral director Harry L. Nikfle
Address 4101 Edmondson Ave.
19. 7-18 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 45, at 11 1/2 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 45, to July 15 19 45
and that I last saw h. alive on July 15 19 45

Immediate cause of death	DURATION
acute Cardiac dilatation	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

22. SIGNATURE S. C. Feldman M. D. or other
Address 1442 E. Balto. Date signed 7/17/45

9-10

12-11

6-8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-C)

06741 F

42

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Halethorpe (Arbutus)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

1337 Lindemere Ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1337 Lindemere Ave, Arbutus

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Sophia Charlotte (Radeck) Flowers

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Andrew J. Flowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 23 - 1869

8. AGE: Years	Months	Days	If less than one day
76	4	20	..... hrs. ..... min.

9. Birthplace Baltimore City and (Town, county, and state)

10. Usual occupation Home Life

11. Industry or business —

FATHER 12. Name Dietrich Ewbart Radeck

13. Birthplace Hanover, Germany

MOTHER 14. Maiden name Catherine Louisa Sweitzer

15. Birthplace Switzerland

16. Informant Mrs. Catherine Mary Wootton

Address 1337 Lindemere Ave, Halethorpe, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/45 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Balto., Md.

Location .....

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 7/14 (Date received by registrar) 19 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 45 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19 45 to July 13 19 45 and that I last saw h.. alive on July 11 19 45

Immediate cause of death	DURATION
(a) Acute Myocarditis	3 days
Due to (b) Chronic Glomerulo Nephritis & Arteriosclerosis	2 yrs
Due to (c) Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. C. Brumbaugh M. D. or other

Address 569 Main St Elkton Md. Date signed 7/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

06742 P

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Baltimore Hdlethorpe
City or town 1930 Northeast Ave.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Hdlethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1930 Northeast Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Ford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb. 2, 1912

8. AGE: Years 33 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name Nathan Ford
13. Birthplace Chas. Co. Md.

MOTHER
14. Maiden name Helen Lewis
15. Birthplace Carroll Co. Md.

16. Informant Helen Kennedy
Address 1930 Northeast Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-12-45 (month) (day) (year)
Cemetery or crematory West Liberty
Location
18. Funeral director Adolphus Halstead
Address 918 Druid Hill Ave.
19. 7/12 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION AM

20. DATE OF DEATH July 9th 1945 at 12.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-18-45 19 to 7-9-45 19 and that I last saw h alive on 7-9-45 19

Immediate cause of death	DURATION
Mitral Insufficiency	
Due to Hypertensive Cardiac	
Due to Disease	
Other conditions Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE C. T. Maloney M.D. M. D. or other
Address Catonsville Md. Date signed 7/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

06743 Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto
City or town Essex 21 Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: off Holly Neck Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Rosspburg, Balto 6 Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 E. Elm ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Gale Ford
3. (b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Amy A. Ford
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 10, 1887

8. AGE: Years 58 Months 3 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Maintenance Dept.
11. Industry or business: Balto.Co.Fire Dept.

FATHER
12. Name: Reese Ford
13. Birthplace: Delaware

MOTHER
14. Maiden name: Mary J. Weller
15. Birthplace: Delaware

16. Informant: Mrs. G. G. Ford
Address: 1 E. Elm Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1945 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto., Md.

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. July 6 - 1945 (Date rec'd by registrar) Dawson L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 11^15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary occlusion — DURATION: Immediate
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 7/4/45
Where did injury occur? Essex Balto. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at Country Home
Means of injury: coronary occlusion Injured at work? No

23. SIGNATURE J. M. [illegible] M.D. — M. D. or other
Deputy Medical Examiner
Address: Dundalk, Md. Date signed 7/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

06744

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Veterans Administration Fac., Ft. Howard, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1219 N. Bentalou St. (If rural, give LOCATION)

2.(a) If veteran, name war: W. W. I

3.(a) FULL NAME: Denwood W. FORWOOD

3.(b) Social Security Number: 216-20-3152

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida E. Forwood

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): December 22, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	15	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Chauffeur - Unemployed

11. Industry or business: Private

FATHER
12. Name: Harry Forwood
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Anna Bowen
15. Birthplace: Baltimore, Md.

16. Informant: Wife - 1219 N. Bentalou St.

Address: 1219 N. Bentalou St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1945 (month) (day) (year)

Cemetery or crematory: Louden Park

Location: Frederick Rd., Balto. Md.

18. Funeral director: Wm. Tickner

Address: Pennsylvania Ave. & North Ave., Balto, Md.

19. 7-10 45 (Date rec'd by registrar) (19) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 19 45 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-5-45 19 45, to 7-7 19 45 and that I last saw him alive on July 7 19 45

Immediate cause of death	DURATION
Sarcoma of left leg	2 yrs.
with lung metastases	plus
Due to: -	
Due to: -	
Other conditions: -	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. -

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. T. Brackin Jr. J. T. BRACKIN, Captain M.C. (M. D. or other)

Address: Fort Howard, Maryland Date signed: 7-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06745

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 26 E. Hamburg St.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JOHN T. FOSTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Foster

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 2-21-92

8. AGE: Years	Months	Days	If less than one day
53	5	9	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Calup Foster
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ida Woods
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: John F. Denny, Inc.
Address: Light & Montgomery Sts., Balto. Md.

19. 8/1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1945 at 7:30P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1945, to July 30, 1945 and that I last saw him alive on July 30, 1945

Immediate cause of death	DURATION
Pulmonary infarct masses	
Due to: Pulmonary embolism	
Due to: Thrombophlebitis left leg	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Herniorrhaphy, right — Date of op. 7-20-45

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C., U.S.A. (Name and title)

Address: Fort Howard, Md. Date signed: 7-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 06746

Reg. Diat. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rose Hill Terrace Box 26

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Henry Gallagher

3.(b) Social Security Number 218-01-6712

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura Baines Gallagher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22nd 1890

8. AGE: Years	Months	Days	If less than one day
55	0	1	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Painter

11. Industry or business Black & Decker Mfg. Co.

FATHER 12. Name James J. Gallagher

FATHER 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Mary M. Stevens

MOTHER 15. Birthplace Pennsylvania

16. Informant Mrs Wm H. Gallagher

Address Rose Hill Terrace Parkville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26th 1945 (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore, Maryland

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. 7-25-45 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Heart Failure, Coronary thrombosis	sudden
Due to Hypertension	Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Rollin E. Hudson MD DME. M. D. or other

Address Towson 4, Md Date signed 7/23/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06747

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 11 mos., 24 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 6 yrs., 11 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 211 Ingleside Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert A. Gibson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anne Gibson
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): July 4, 1883

8. AGE: Years	Months	Days	If less than one day
62	0	7	....hrs. ....min.

9. Birthplace: Union Bridge, Maryland (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business
FATHER 12. Name: Joseph P. Gibson
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Lydia Galloway
15. Birthplace: Baltimore, Maryland
16. Informant: Albert A. Gibson
Address: 211 Ingleside Ave., Catonsville, Balto. Co., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14, 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: Baltimore, Maryland
18. Funeral director: Edw. S. MacNabb
Address: Frederick & Wade Aves. Catonsville, Maryland
19. July 11 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945, at 2:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1938, to July 11, 1945 and that I last saw him alive on July 11, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	7 yrs. 6 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A Shaffer M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 7/11/45

Rec'd - 7-13-45 - Dr. E.E. Nichols

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (834)

06748

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore Co
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
623 E St Sparrows Point
How long in hospital or institution? Joshua George Gladfelter

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: 623 E St Sparrows Pt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 623 E St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joshua George Gladfelter.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Gladfelter
8.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): April 4th 1873

8. AGE: Years: 72 | Months: 3 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: York Co Pa (Town, county, and state)
10. Usual occupation: Asst Steam Engineer
11. Industry or business: Bethlehem Steel
FATHER 12. Name: Albert Leland Gelfelter
13. Birthplace: Pa
MOTHER 14. Maiden name: Sarah Kleindienst
15. Birthplace: Pa
16. Informant: J Luse Gladfelter
Address: 2350 Pelham Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13/45 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem
Location: City
18. Funeral director: Ulrich Funeral Home
Address: 2008 Orleans St
19. 7-11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10th 1945, at 10 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to July 10 1945 and that I last saw h. alive on July 9 1945

Immediate cause of death	DURATION
Cerebral Cerebral Occlusion	4 days
Due to: Arteriosclerosis - Gen.	10 yrs.
Due to: Chronic Congestive Heart	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C E Lindsay M D
M. D. or other
Address: 620 E St. Sp Pt Md Date signed: 7-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06749

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Dundalk, Balt. Co. Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 832 N. Howard St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Catherine Gloria.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single.

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 24 1931

8. AGE: Years 13 | Months 11 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Homestead Va.
(Town, county, and state)

10. Usual occupation School Girl.

11. Industry or business

FATHER
12. Name Diedo Gloria
13. Birthplace New Mexico

MOTHER
14. Maiden name Mabel M. Davis
15. Birthplace Harrisburg Va.

16. Informant Mabel M. Gloria
Address 832 N. Howard St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/45 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location 930 Frederick Road.

18. Funeral director John J. Cowan & Son
Address 901 & 903 Hollins St.

19. 7/10/45 19... John H. Connolly 7/12/45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 45, at 8:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
D. A. Driving	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident: Date of 7-6-45.
Where did injury occur? Dundalk (City or town) Balto. Co. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury — Injured at work? No

23. SIGNATURE D. A. Davis M.D.
Address Asst. Supt. Bur. Crim. - Dundalk Md. (M. D. or other)
Date signed 7-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06750 P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore County
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4½ months
~~Hospital~~, ~~Institution~~, or street address where death occurred: 3109 Arden Ave, Dundalk
How long in ~~hospital~~ or ~~institution~~? 4½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7001 Dunmore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Clara Bonsor Gordon

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: John Churnside Gordon deceased
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): February 27, 1890

8. AGE:

Years	Months	Days	If less than one day
55	4	22	— hrs. — min.

9. Birthplace: Lorain Lorain Co. Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: William F. Bonsor
13. Birthplace: Ohio

MOTHER
14. Maiden name: Florence Mapes
15. Birthplace: Ohio

16. Informant: William F. Gordon
Address: 3109 Arden Ave, Dundalk

17. Cremation (Burial, cremation, or removal, which?) Date thereof July 23rd (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: City

18. Funeral director: Ulrich Funeral Home
Address: 2008 Orleans St.

19. 7-20-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943, 1943, to July 19, 1945, and that I last saw h.. alive on June 10, 1945.

Immediate cause of death: Uremia.

	DURATION
Due to: Circumcentric metastasis and local extension	3 mos.
Due to: Carcinoma of rectum with skin type.	1½ yrs.
Other conditions: Metastasis to lungs, local growth	5 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: none
— Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas F. Johnson, M. D. or other
Address: 113 N. Markham St. Date signed: July 19, 19..

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06751

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d) 30

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
5501 Edmondson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: ----------

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5904 Berkley Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3. (a) FULL NAME

Mrs. Mary Elizabeth Gray

3. (b) Social Security Number

----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard L. Gray

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ----------

8. AGE: Years	Months	Days	If less than one day
About 82	----	----	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: John T. Webster

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Brooks

MOTHER — 15. Birthplace: Maryland

16. Informant: Wilmer P. Webster

Address: 5904 Berkley Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/3/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md.

18. Funeral director: H. H. Mears and Son

Address: 805 N. Calvert St.

19. 7/2 19 45 (Date rec'd by registrar) V. C. Cordrey Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 45 at 6-10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to July 1 19 45 and that I last saw her alive on June 30 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr.
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: ----------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of: ----------

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work?: ----------

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 7-2

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeberg #6
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7300 Belair Rd.
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Raspeberg P.O. #6
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7300 Belair Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albert P. Hagen.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Adele Hagen.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 24/1888

8. AGE: Years: 57 | Months: 1 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore City, (Town, county, and state)
10. Usual occupation: Erector
11. Industry or business: Sparrows Pt. yard.
FATHER 12. Name: Christian Hagen.
FATHER 13. Birthplace: Germany.
MOTHER 14. Maiden name: Ida
MOTHER 15. Birthplace: Germany.
16. Informant: Mrs. Adele Hagen.
Address: 7300 Belair Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/1/45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Ba. Co. Md.
18. Funeral director: N. W. E. Dupp & Sons
Address: 7110 Belair Rd.
19. 7/30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945, at 2 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. McBarnette M.D.
M. D. or other
Address: Govans Md. Deputy Medical Examiner
Date signed: 7/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

06753

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Ft. Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
Veterans Adm. Fac., Fort Howard, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 902 Bennett St.
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W.I

3.(a) FULL NAME: George W. HALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Stella Hall
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): November 22, 1887

8. AGE:	Years	Months	Days	If less than one day
	57	7	15	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business: Mechanic
FATHER 12. Name: William Hall
FATHER 13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Josephine Reid
MOTHER 15. Birthplace: Virginia
16. Informant: Wife and Clinical Records
Address: 902 Bennett St., Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, '45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location:
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N Schroeder St
19. 7-11-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 19 45, at 4:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 19 45, to July 7 19 45 and that I last saw him alive on July 7 19 45

Immediate cause of death	DURATION
Disease of the Heart — hypertension and coronary arterio-sclerosis, cardiac enlargement, myocardial insufficiency, auricular fibrillation.	8 mo pl.
Due to:	
Other conditions: Chronic interstitial nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, Major M.C. (M. D. or other)
Address: Fort Howard, Md. Date signed: 7-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

06754

CERTIFICATE OF DEATH

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Garrison

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 25 yrs.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Garrison

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Reisterstown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lucy Bell Harden

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Jesse A Harden

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 18 - 1872

8. AGE: Years	Months	Days	If less than one day
73	3	8	..... hrs. ..... min.

9. Birthplace: Poughkeepsie N. Y. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Thomas Foster

FATHER 13. Birthplace: Poughkeepsie N. Y.

MOTHER 14. Maiden name: Amelia

MOTHER 15. Birthplace: Poughkeepsie N. Y.

16. Informant: Morris Harden

Address: Pikesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant

Location: Gamber, Carroll Co. Md.

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 7/28/45 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1945 at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1935 to July 26th 1945 and that I last saw her alive on July 26th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to: Coronary Sclerosis	2 yrs
Due to: Art. Sclerosis	5 yrs
Other conditions: Acute Enteritis	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James G. Miller M. D. M. D. or other

Address: Pikesville, Md. Date signed: 7/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

06755

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Near Rosedale Ave (Essex)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Rt #40 Philadelphia Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Tab. as Balto.
(For newborn infants give residence of mother)
State: Md. County:
City or town: Perry Point Hospital
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Alley Hardman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23 - 1915

8. AGE: Years: 30 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Weston W. Va.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: -

FATHER
12. Name: Samuel A Hardman
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Ruby D. Hornbeck
15. Birthplace: Kingston N.Y.

16. Informant: Essex Postal Dept.
Address: Essex, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/45 (month) (day) (year)
Cemetery or crematory: Balto. national
Location: Frederick Rd.

18. Funeral director: John D Connelly
Address: 418 Eastern Ave. Essex 21

19. 7/22/45 (Date rec'd by registrar) John D Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1945, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945, to July 21 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture Skull	Immediate
compound (crushed)	
Due to: Multiple fracture	
Due to: left arm	
Other conditions: Shock.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/21/45
Where did injury occur? Rosedale #40 Rd Balto. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public Road
Means of injury: Auto. Injured at work? No

23. SIGNATURE: J M Cammack MD
M.D. or other
Address: Dundalk Md Date signed: 7/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (552) ne

06756

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 N. Carlton St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: ARTHUR JAMES HARDY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1920

8. AGE: Years	Months	Days	If less than one day
25	5	11	hrs. min.

9. Birthplace: Pittsburgh, Pa.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Henry Hardy
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Bland
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Facility
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/12/45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 7/12 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1945, at 1:58P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to July 8, 1945 and that I last saw him alive on July 8, 1945

Immediate cause of death	DURATION
Carcinoma, colloid, with generalized abdominal metastases	6 Months plus
Due to: Primary site unknown. Supp.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C. MEDICAL DIR.

Address: Fort Howard, Md. Date signed: 7-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151-2)

CERTIFICATE OF DEATH

06757

★ Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Texas Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Albert L. Hauptman

3.(b) Social Security Number: 216-07-3910

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Gertrude (nee Mahoney)

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 18, 1881

8. AGE:

Years	Months	Days	If less than one day
64	1	3	....hrs. ....min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Supt.

11. Industry or business: Veneers

FATHER 12. Name: Gerhardt Hauptman

13. Birthplace: Germany

MOTHER 14. Maiden name: Mary S Laeffer

15. Birthplace: Unknown

18. Informant: Mrs. A. L. Hauptman

Address: Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1945 (month) (day) (year)

Cemetery or crematory: St. Joseph's Church

Location: Texas, Maryland

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. June 22 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1945, at 5-30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1943, to July 21 1945

and that I last saw h.. alive on 7/20 1945

	DURATION
Immediate cause of death: Chronic Nephritis (Coma)	3 yrs
Due to:	
Due to:	
Other conditions: Secondary Anemia	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, Industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. M. D. or other

Address: Cockeysville Md. Date signed 7/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1945 C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06758

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 9 months, 9 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 9 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: White Hall P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Alec Hausknecht

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): November, 1866 ???

8. AGE: Years	Months	Days	If less than one day
78??	8		....hrs. ....min.

9. Birthplace: Putty Hill, Maryland ???
(Town, county, and state)

10. Usual occupation: farm hand

11. Industry or business: farming

FATHER
12. Name: Frank Hausknecht
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine ??
15. Birthplace: Germany

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-7-45 (Month) (day) (year)

Cemetery or crematory: St. Joseph's Cem.

Location: Balto Co. Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd

19. 7/5/45 (Date rec'd by registrar) 19 45 H. C. Rudisill Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 19 45, at 7:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 19 41, to July 4 19 45

and that I last saw him alive on July 4 19 45

Immediate cause of death	DURATION
Terminal pneumonia	24 hours
Due to Phlebitis, left leg	10 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M. D. or other

Address: Catonsville-28, Md. Date signed 7/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06759

★ Reg. Diat. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sister Mary Miloslava Havlic

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25, 1877

8. AGE:

Years	Months	Days	If less than one day
67	11	10	..... hrs. ..... min.

9. Birthplace: Czechoslovakia (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER

12. Name: Francis Havlic

13. Birthplace: Czechoslovakia

MOTHER

14. Maiden name: Julia Hodek

15. Birthplace: Czechoslovakia

16. Informant: Sr. Mary Clara

Address: Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13/45 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen Arm

18. Funeral director: Geo. M. Smith & Son

Address: 841 W. Lexington St.

19. 7/12/45-19 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 19 45, at 9.35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11, 1931 19 31, to July 10 19 45 and that I last saw h[illegible] alive on July 5, 1945 19 45

Immediate cause of death	DURATION
Myocardial Decompensation	6 mos.
Due to	
Due to	
Other conditions: Arteriosclerosis	2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

06760

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 12 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 years, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Maryland House of Correction

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Jessups,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Eugene Hawley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Eva Doyle

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 6, 1864

8. AGE:	Years	Months	Days	If less than one day
	81	5	16	...hrs. ...min.

9. Birthplace: Charlottesville, Virginia (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business: None

FATHER — 12. Name: William R. Hawley

FATHER — 13. Birthplace: Charlottesville, Virginia

MOTHER — 14. Maiden name: Frances Mooney

MOTHER — 15. Birthplace: Charlottesville, Virginia

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 17, 1945 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 8/12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 45, at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 42, to July 22 19 45 and that I last saw him alive on July 22 19 45

Immediate cause of death	DURATION
Hypertensive cardio-renal-vascular disease	Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 7/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Fa)

CERTIFICATE OF DEATH

06761

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 18 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 month, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: --
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Samuel D. Hesson

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	separated

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 31, 1876

8. AGE:

Years	Months	Days	If less than one day
69	3	13	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: --

FATHER
12. Name: Abraham Hesson
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Catherine Sprinkel
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 17, 1945 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 8/17/45 (Date rec'd by registrar) H. C. Andrea Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1945, at 6:55 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 26, 1945, to July 14, 1945 and that I last saw him alive on July 14, 1945

Immediate cause of death	DURATION
Broncho pneumonia with acute pulmonary oedema	2 days
Due to: Hypertensive Cardio-renal-vascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 7/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 1 day

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1105 Hollins Street

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Kate Hill

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: Frank Hill

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): February 9, 1873

8. AGE:	Years	Months	Days	If less than one day
	72	5	18	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER — 12. Name: John H. Smith

13. Birthplace: U.S.A.

MOTHER — 14. Maiden name: Mary R. Beziet

15. Birthplace: U.S.A.

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-45 (month) (day) (year)

Cemetery or crematory: London Park

Location: 3801 Frederick Rd

16. Funeral director: Harry H Witzke

Address: 4101 Edmondson Ave.

19. 7/28 45 A.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1945, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardio vascular disease	
Due to: fractured humerus	
Other conditions: sudden death	
Inquest	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of July 26 45

Where did injury occur? Catonsville Baltimore Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury: walking backward fell down Injured at work?

23. SIGNATURE: Geo. L. Kieffer Asst. Med Dir

M. D. or other

Address: 1010 Leeds ave Date signed: 7-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

06763 P.

Reg. Diat. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5302 Edmondson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine Elizabeth Hinkle

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Harry C Hinkle
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): February 6 - 1876

8. AGE: Years	Months	Days	If less than one day
69	5	14	...hrs. ...min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: house wife
11. Industry or business —

FATHER
12. Name: John Schaeffer
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Catherine Thomas
15. Birthplace: Neuenburg Germany

16. Informant: Mary Boos
Address: 2422 E. Monument St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23 1945 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto Md.
18. Funeral director: Robert L. Steele
Address: 2100 Edmondson Ave.

19. 7/21/45 (Date rec'd by registrar) Alo. Hedrick Registrar DM.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 - 1945, at 5:15 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 30 - 1943, to July 20 - 1945 and that I last saw her alive on July 20 - 1945

Immediate cause of death	DURATION
Cerebral Hemmorhage	14 hours
Due to: Hypertension	unknown
Due to:	
Other conditions: Organic Heart Disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Chester Riland. M.D.
Baltimore (23) M. D. or other
Address: 2532 Edmondson Ave. Date signed: 7-20-1945

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13ha) Bc)

CERTIFICATE OF DEATH

P. 07428

Reg. Diat. No.

File No. C 937 AUG 31 1945

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: 512 Riverside Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 S. Montford Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

3. (a) FULL NAME LELIA BLANCHE HOOPER

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17. 1872

8. AGE: Years	Months	Days	If less than one day
73 -74-	5	5	..... hrs. ..... min.

9. Birthplace: Anne Arundel County Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: James Smith

13. Birthplace: Md.

MOTHER 14. Maiden name: Not Known

15. Birthplace: Md.

16. Informant: Mr. Allen Hooper (Son)

Address: 1519 Montpelier St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul. 24. 1945 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore Md.

18. Funeral director: HENRY SANDER & SONS. INC.

Address: North Ave. & Broadway.

19. 7/24 19 41 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21. 1945 at 7.45 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 19 45, to July 21 19 45

and that I last saw h... alive on July 21 19 45

Immediate cause of death	DURATION
Cardio-Vascular-Renal disease	1 yr.
Due to	
Due to	
Other conditions no	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White M.D.

M. D. or other

Address 7601 Easton Ave Baltimore 24, Md Date signed 7/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06764

Reg. Dist. No. 8-38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since June 25, 1945
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since June 25, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4011 Derby Manor Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Hamill Hooper

3.(b) Social Security Number: 216-18-0233

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude Nielson Hooper
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 3, 1889

8. AGE:

Years	Months	Days	If less than one day
56	1	7	...hrs. ...min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Engineer - Civil
11. Industry or business: Wiley & Co., Inc.
FATHER 12. Name: Walter Hooper
13. Birthplace: Maryland (Balto.)
MOTHER 14. Maiden name: Olivia Hemmill
15. Birthplace: Maryland (Balto.)
16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/14/45 (month) (day) (year)
Cemetery or crematory: Loudon Pk. Cem.
Location: Balto., Md.
18. Funeral director: Wm. J. Tichenor & Sons
Address: Balto., Md.
19. 7/12 1945 (Date rec'd by registrar) D. O. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945, at 8:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945, to July 10 1945
and that I last saw him alive on July 10 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	about 6 years
Due to	
Due to	
Other conditions: aortic aneurysm	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M.D.
Address: Towson 4, Maryland Date signed: 7-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

Reg. Diat. No. 66765

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore County

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5169 Viaduct Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: City of Balto.

City or town: City of Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2128 St. Paul Street

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: GRACE DENIS JACKSON

3. (b) Social Security Number: 046 - 09 - 1326

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Harry Ing Jackson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): August 13, 1885

8. AGE: Years	Months	Days	If less than one day
59	10	20	...hrs. ...min.

9. Birthplace: Zanesville, Ohio (Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER 12. Name: Charles R. Denis

13. Birthplace: Zanesville, Ohio

MOTHER 14. Maiden name: Emily Marsh

15. Birthplace: Youngstown, N. Y.

16. Informant: Mrs. Grace D. Jackson (Self)

Address: 2128 Saint Paul Street, Balto., Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 6, 1945 (month) (day) (year)

Cemetery or crematory: Green Mount Cemetery

Location: Baltimore City, Maryland

18. Funeral director: Stewart & Mowen Company

Address: 108 W.North Av.(W.F.Wooden-Suc.)Balto.

19. 7/6/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1945 at 4 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 24th 1945, to July 3 1945 and that I last saw h... alive on June 30 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	1 Day
Due to Carcinoma of the liver	11 yrs
Due to	
Other conditions Abdominal ascites	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

SIGNATURE: Frederick Bentley M. D. or other

Address: July 5 - 45 Date signed: 7-5-45

Evidence for change of usual residence of deceased is shown on File No. G 98 SEP 17 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 06766 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 47 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Talbot Caroline

City or town: ~~Ridgley~~ Oxford (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: RAYMOND JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 11-4-94

8. AGE: Years	Months	Days	If less than one day
50	7	6	... hrs. ... min.

9. Birthplace: Oxford, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: George Jones

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Kuff

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/14/1945 (month) (day) (year)

Cemetery or crematory:

Location: Easton Maryland.

18. Funeral director: A. Lee Oder

Address: 4644 York Rd, Balto,

19. July 11th 19 45 (Date rec'd by registrar) [signature] Local Deputy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1945 to July 11, 1945 and that I last saw him alive on July 11, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv. Active	1 Year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work? No

23. SIGNATURE: A M Balter M.D. or other

A.M. BALTER, LT. COL., M.C. CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 7-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06767

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay, Mary Land.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 6 days 22 hrs 40 min.
Hospital, institution, or street address where death occurred:
Relay Sanitarium.
How long in hospital or institution? Since January 18th 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rogers town.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 247 S. Prospect St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edgar S. Keefer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6.(b) Name of husband or wife: Mary Editha Keefer.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25th 1871

8. AGE:

Years	Months	Days	If less than one day
73	7		22 hrs. 40 min.

9. Birthplace: Wilsons, Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:
FATHER 12. Name: Samuel Keefer
13. Birthplace: Hagerstown Wash Co Md
MOTHER 14. Maiden name: Mollie Zeutmyer.
15. Birthplace: Hagerstown Wash Co Md
16. Informant: Wife.
Address: 247 S. Prospect St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-28-45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown
18. Funeral director: C. M. Suter & Son
Address: 305 N Potomac Hagerstown
19. July 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25th 1945, at 10 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/18/ 1945, to 7/25 1945, and that I last saw h[illegible] alive on 7/25/ 1945

Immediate cause of death	DURATION
Cardio Respiratory failure	
Due to: Arterio sclerotic Cardio	
Due to: Vascular Disease	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Cliff Ralph M. D. M. D. or other
Address: St. Agnes Hosp Date signed 7/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06768

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 5 mos., 8 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 1 year, 5 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1027 Wilmot Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Verna Kelly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Kelly
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1889

8. AGE:	Years	Months	Days	If less than one day
	56	6	29	hrs. min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William C. Childs
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Mary Louisa Ghent
15. Birthplace: Baltimore County, Maryland

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/45 (month) (day) (year)
Cemetery or crematory: Chestnut Ridge
Location: Harford County
18. Funeral director: Luhr-Garden Inc
Address: 403 S. Wolfe St

19. 7/30 19 45 (Date rec'd by registrar) E. C. Lindsay Deputy Local Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 19 45, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 22 19 44, to July 30 19 45 and that I last saw her alive on July 30 19 45

Immediate cause of death	Duration
Pulmonary oedema	1 hour
Due to: Terminal right broncho pneumonia	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed: 7/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ha) Pa

06769 P

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1316 W. Mulberry St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leonard Kerry.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colord	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace: Garland N.C (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Sparrows Point
FATHER 12. Name: Henry J. Kerry.
FATHER 13. Birthplace: N.C.
MOTHER 14. Maiden name: Lillie Melvin
MOTHER 15. Birthplace: N.C.
16. Informant: Gertrude Christian
Address: 109 W. 112 St N.Y. City
17. Burial, cremation, or removal. Which?: Burial Date thereof: July 20-45 (Month) (day) (year)
Cemetery or crematory: Garland N.C
Location:
18. Funeral director: James A. Davis
Address: 142 W. Fifth St
19. (Date rec'd by registrar): 7/7/45 19 Registrar: A. W. Fredrick Sgt

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16th 19 45, at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary Occlusion	5 min.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Davis M.D.
Asst Supt. Md. Gen. - Balto. M.D. or other
Address: Garland - Md. Date signed: 7-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd
7/17/45
V.S.

06770 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
2901 Linwood Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2901 Linwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: AMELIA KOERBER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Phillip Koerber
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 17, 1839

8. AGE: Years	Months	Days	If less than one day
75	11	5	....hrs. ....min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Carl Frederick
13. Birthplace: Germany

MOTHER
14. Maiden name: Amelia Schmidt
15. Birthplace: Baltimore

16. Informant: Mr. Edward Koerber (Son)
Address: 2901 Linwood Ave. Parkville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore County Md.
18. Funeral director: HENRY SANDER & SONS. INC.
Address: North Ave. & Broadway.

19. 7/24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July. 22. 1945 at 5.00 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to 7/22 1945
and that I last saw h... alive on 7/22 1945

Immediate cause of death	DURATION
Cardio Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: ..... M. D. or other
Address: 5702 Harford Rd Date signed 7/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06771

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Old Frederick Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Virginia Legg
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Maurice K. Legg
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): October 1, 1871
8. AGE: Years 73 Months 9 Days 7 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md. (Town, county and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: William J. Stewart
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Julia V. Reid
15. Birthplace: Phila. Pa.
16. Informant: Maurice Roydon Legg
Address: Catonsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem
Location: Baltimore, Md.
18. Funeral director: E. Willis Lamoreau
Address: 1003 W. Baltimore St.
19. 7/11 1945 (Date rec'd by registrar) H. C. Andrews Registrar Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945, at 1:45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1945, to July 8 1945
and that I last saw her alive on July 8 1945

		DURATION
Immediate cause of death	Cerebral hemorrhage	2 days
Due to	Hypertension	
Due to		
Other conditions	Arterio-sclerosis	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. W. Hening M.D. (M. D. or other)
Address: 203 Ingleside Ave. Catonsville 28, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23) BC

06772

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 3 months

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 5 years, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1214 Union Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Joseph Lamprey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eva Lamprey

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 21, 1874

8. AGE:	Years	Months	Days	If less than one day
	71	-	14	....hrs. ....min.

9. Birthplace: Massachusetts
(Town, county, and state)

10. Usual occupation: Carpenter's helper

11. Industry or business: Carpentering

FATHER
12. Name: Joseph Lamprey
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Rose Lapiere
15. Birthplace: Canada

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-8-45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: 3901 Old Frederick Rd.

18. Funeral director: Harry W. Feilitzke

Address: 4101 Edmondson Ave

19. ..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 19 45 at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1940, to July 5 1945 and that I last saw him alive on July 5 1945

	DURATION
Immediate cause of death: Terminal pneumonia	24 hours
Due to: Cerebral thrombosis	48 hours
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 7/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-a)

CERTIFICATE OF DEATH

06773 P

Reg. Dist. No. 35

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, Institution, or street address where death occurred:
Annacost Nursing Home
How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 812 Register Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rebecca J. Levi

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~ Henry R. Levi
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11, 1867

8. AGE: Years	Months	Days	If less than one day
78	2	8	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name August Kaelte
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Aetrodtin
15. Birthplace Germany

16. Informant Mrs. B. Niedlinger
Address Halesburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/45 (month) (day) (year)
Cemetery or ~~crematory~~ Baltimore Hebrew
Location Balto. Md.
18. Funeral director Blank Bressler & Levy
Address 1902 Eutaw Place
19. 7/21/45 Balto. Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 11:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945, to July 19 1945
and that I last saw h~~er~~ alive on July 18, 1945

Immediate cause of death	DURATION
Apoplexy	sudden
Due to Arterio-Sclerosis &	
Due to Hypertension	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Hurt Green M.D.
M. D. or other
Address Towson, Md. Date signed 7-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06774

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 19 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 2 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5100 Cordelia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Abe F. Levin

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Belle Raksin
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 1873?

8. AGE: Years	Months	Days	If less than one day
72?			...hrs. ...min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: tailor
11. Industry or business: Tailoring

FATHER
12. Name: ?
13. Birthplace: Russia

MOTHER
14. Maiden name: ?
15. Birthplace: Russia

16. Informant: Hospital Records
Address: Baltimore-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-45 (month) (day) (year)
Cemetery or crematory: Hebrew Friendship
Location: Dolfield & Cooks Lane
18. Funeral director: Jack Lewis Inc
Address: 1439 E. Balto St
19. 7/5/45 (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 19 45 at 4:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1945 19 to July 5 19 45 and that I last saw him alive on July 5 19 45

Immediate cause of death	DURATION
Terminal pneumonia	10 hours
Due to: Chronic Myocarditis	Indef.
Due to: Hypertensive cardiovascular disease	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M. D.
Robert E. Gardner M. D. or other
Address: Catonsville-28, Md. Date signed 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 59

CERTIFICATE OF DEATH

Reg. Dist. No. 06773 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Paradise (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Bonney Veiw Hilins & Kenwood
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 407 N Belnord Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Caroline Limpert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 13 1858

8. AGE: Years	Months	Days	If less than one day
86	8	2	hrs. mio.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: August Limpert
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Froelich
15. Birthplace: Germany

16. Informant: Charles Limpert
Address: 4346 Parkside Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Ave Balto Md
18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St

19. 7/17/45 (Date rec'd by registrar) 19 awdedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945 19 5.30 pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1 19 45 to 7/15 19 45 and that I last saw her alive on 7/14 19 45

Immediate cause of death	DURATION
Uremia Sclerosis	
Due to Hypertension	
Due to	
Other conditions: Primary Epithelioma of face. Amputation 5 years ago R.L.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas A Carlson M. D. or other
Address: 2145 W Balto St Date signed: 7/16/45

Rec'd VS
7/17/ [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (850)

CERTIFICATE OF DEATH

06776

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Spring House

How long in hospital or institution? 1 year 2 mos 22 d

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ellicott St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Grace Gambrill Macgill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1857

8. AGE:

Years	Months	Days	If less than one day
87	8	26	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co., Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William A. Macgill

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Maria Gambrill

15. Birthplace: Anne Arundel Co., Md.

16. Informant: Mrs. Blanche M. Sensindiver

Address: Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20, 1945 (month) (day) (year)

Cemetery or crematory: St. John's Cemetery

Location: Ellicott City, Md.

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. 7/20/45 (Date rec'd by registrar) 19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945, at 8.30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 26 1945 to July 18 1945

and that I last saw h.. alive on July 17 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: General Arterio-Sclerosis & Hypertension	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eliot W. Johnson M.D. M. D. or other

Address: 3432 Frederick Ave. Date signed: 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06777

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred: -
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alfreda F. Maglidt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edgar M. Maglidt
B.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1887

8. AGE: Years	Months	Days	If less than one day
57	9	21	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: David M. Gray
13. Birthplace: Virginia
MOTHER 14. Maiden name: Rosetta Jenkins Gray
15. Birthplace: Virginia
16. Informant: Edgar M. Maglidt
Address: Reisterstown Rd. Garrison, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2, 1945 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Maryland
18. Funeral director: Frank H. Purnell
Address: Pikesville, Maryland
19. July 2 1945 (Date rec'd by registrar) Mary B. Kline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945 at 4.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to July 1 1945 and that I last saw h.e.r. alive on July 1 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to	
Due to	
Other conditions: Arteriosclerosis, Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: Injured at work?

23. SIGNATURE: James L. Duffell M. D., or other
Address: Reisterstown Md. Date signed: 7/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06778

CERTIFICATE OF DEATH

Reg. Dist. No. 38

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Joppa Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mountain Ave nr Satyr Hill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Joppa Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mountain Ave nr Satyr Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen Marx

3. (b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: ~~married~~ widow
6.(b) Name of husband or wife: John C.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 13 1869
8. AGE: Years: 76 Months: 3 Days: 11 If less than one day: hrs. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER 12. Name: ? Nisson
13. Birthplace: Germany
MOTHER 14. Maiden name: ?
15. Birthplace: Germany
16. Informant: Mrs Ella Sehlegel
Address: Mountain Ave nr Satyr Hill Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-26-45 (month) (day) (year)
Cemetery or crematory: Maryland Park
Location:
18. Funeral director: L. J. Rock
Address: 5305 Hereford Rd.
19. 7-25 1945 (Date rec'd by registrar) G. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945 at 1 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1945, to July 24 1945 and that I last saw h[illegible] alive on July 24 1945

	DURATION
Immediate cause of death: Chronic myocarditis with hypertension	15 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. M. Bacon M.D. or other
Address: 2510 Madison Ave. Date signed: July 25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06779

CERTIFICATE OF DEATH ★

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? June 22, 1945

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? since June 22, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's Co.

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6215 41st Street, Place

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Lee J. McNEILL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Mrs. Thelma McNeill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 13, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	22	..... hrs. ..... min.

9. Birthplace Manchester, North Carolina (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER — 12. Name John S. McNeill

13. Birthplace Fayetteville, N.C.

MOTHER — 14. Maiden name Sallie Jordan.

15. Birthplace ?

16. Informant Mrs. Thelma Mc Neill

Address 6215 41st. Place Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-45 (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore Md.

18. Funeral director H. Stonebraker Sons

Address 2101 Frederick Ave Balto, Md

19. 7/5 19 45 (Date rec'd by registrar) H. C. Conaway Registrar

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 19 45 at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22nd 19 45 to July 4th 19 45 and that I last saw h... alive on July 4th 19 45

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to Endocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Vegetative bacterial endocarditis, Thrombosis, lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gertrude J. Fleischman M.D. M. D. or other

Address Spring Grove St. Hosp. Date signed July 4th 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUN 14 1945
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D BE

06780 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs., 7 mos., 21 das.
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 7 yrs., 7 mos., 21 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and giva nearest town)
Street No. 3115 Abell Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Marie Meister

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: - - -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1882

8. AGE: Years	Months	Days	If less than one day
62	7	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Bookkeeping operator
11. Industry or business: Clerical
FATHER 12. Name: Edward Meister
13. Birthplace: Germany
MOTHER 14. Maiden name: Emilie Sauer
15. Birthplace: Baltimore, Maryland
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 7/23/45 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 45 at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 19 37 to July 21 19 45
and that I last saw h e s alive on July 20 19 45
Immediate cause of death: Bronchopneumonia
Due to: Carcinomatosis of st. lung
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION: Indef.
Major findings of operations:
Date of op.:
As above
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robt. E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed 7/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. G 97 AUG 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 33

06781

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Pensterstown (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Mt Pleasant Sanatorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Linden Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? 35 years

3 (a) **FULL NAME** Harry Miller

3 (b) If veteran, name war

3 (c) Social Security No. 213-03-3504

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Cecilia Miller

6. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1903

8. AGE: Years 41 | Months -42 | Days 7 | If less than one day 4 hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Tavern Manager

11. Industry or business

FATHER
12. Name Abraham Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Miller
15. Birthplace Russia

16 (a) Informant Cecilia Miller
(b) Address 2244 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24/45 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 (a) 7/24/45 (Date rec'd by registrar) (b) A W Schmidt Registrar

MEDICAL CERTIFICATION

20. Date of death July 23, 1945, at 7 58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1945, to July 23, 1945, and that I last saw him alive on July 23, 1945

Immediate cause of death	Duration
Myocardial Collapse.	
Due to Pulmonary Tuberculosis	1½ yrs.
Due to Diabetes Mellitus	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Shuri MD (M. D. or other)
Address Pensterstown Md. Date signed July 23, 1945

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

213-03-3504

Reid VS
7/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

P

P6782 34

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Balto
City or town: Lochearn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3633 Oak Ave - Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Lochearn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3633 Oak Av Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Warren B. Mister

3. (b) Social Security Number: 212-07-8227

4. Sex	5. Color or race	6. ~~(a) Single~~, married, ~~widowed, or divorced~~
Male	White	Married

B.(b) Name of ~~husband or~~ wife: Beatrice Mister
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec 5th 1907

8. AGE: Years	Months	Days	If less than one day
37	7	13	..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Glenn L. Martin

FATHER
12. Name: Benjamin Mister
13. Birthplace: Balto Md.

MOTHER
14. Maiden name: Bertha Jones
15. Birthplace: Raleigh N.C.

16. Informant: Mrs. Beatrice Mister
Address: 3633 Oak Ave - Lochearn
17. Burial (Burial, cremation, or removal? Which?) Date thereof 7/21/45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Co Md
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St
19. 7-19 19 45 Dr Kurt Levy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18th 1945 at 5 50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1943 to July 18 1945
and that I last saw h~~e~~ alive on July 18 1945

Immediate cause of death	DURATION
Lymphosarcoma of the orbita - sinus and scalp	
Due to	
Due to	
Other conditions: Arthritis - jaundice	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: KURT LEVY, M.D.
2301 Eutaw Place
Lafayette 0373 Baltimore 17, Md.
M. D. or other
Address ..... Date signed 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

6783

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Parkelwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkelwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Kolb Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME George Mogg

3.(b) Social Security Number 219-20-9485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen M. Mogg
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2nd 1895

8. AGE: Years	Months	Days	If less than one day
50	1	0	..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual occupation Baker
11. Industry or business
FATHER 12. Name Richard Mogg
FATHER 13. Birthplace Pennsylvania
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown
16. Informant Mrs George Mogg
Address 18 Kolb Ave Parkelwood
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1945 (month) (day) (year)
Cemetery or crematory Parkwood
Location Balto. Md.
18. Funeral director Loudenslow Funeral Home
Address 7401 Belair Road
19. July 6 - 1945 (Date rec'd by registrar) Mrs. G. L. Riffindon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 19 45 at 1 M 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 44 to July 2 19 45 and that I last saw h..... alive on July 1 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day.
Due to Grand Arteriosclerosis	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Herbert F. Shellman M D
M. D. or other
Address 6 E Biddle St Date signed 7/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

G. E. Biddell

Dr. Goldman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

06784

38

Reg. Dist. No. 3

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since June 5, 1945

Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since June 5, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Back River Neck, Essex R 13

(If outside city or town limits, write RURAL and give nearest town) B4-395

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: JOHN MOROZ

3. (b) Social Security Number: 213-01-4614

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Marie Moroz

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): November 19, 1905

8. AGE: Years: 39 Months: 8 Days: If less than one day: hrs. min.

9. Birthplace: Baltimore County, Md (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER 12. Name: Albert Moroz

FATHER 13. Birthplace: Poland

MOTHER 14. Maiden name: Justine Willeski

MOTHER 15. Birthplace: Poland

16. Informant: Personal History Hospital Records

Address: Eudowood Sanatorium Towson 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul. 17 1945 (month) (day) (year)

Cemetery or crematory: Christ Ev. Luth. Ch. Cem.

Location: Baltimore County

18. Funeral director: HENRY SANDER & SONS. INC.

Address: North Ave. & Broadway

19. 7/16 1945 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1945 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945 to July 13 1945 and that I last saw him alive on July 13 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	19 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M. D.

Address: Towson 4 Maryland Date signed: 7-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-E)

06785

CERTIFICATE OF DEATH

Reg. Dist. No. 44

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Baltimore

City or town Rt 13 - Box 454 - Balto 21

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town Ene

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 13. Box 454 - Balto 21

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Nadolny

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife John Nadolny

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) nov 4 - 1869

8. AGE:

Years	Months	Days	If less than one day
75	8	20	..... hrs. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation at Home

11. Industry or business -

FATHER

12. Name antoni Gaspar

13. Birthplace Poland

MOTHER

14. Maiden name Katherine Novak

15. Birthplace Poland

16. Informant Mrs. Bengier

Address Rt. 13 - Box 454 - Balto 21

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory St. Stanislaus

Location Dundalk Ave.

18. Funeral director John J. Connelly

Address 418 Eastern Ave. Cney 21.

19. 7/25/ 1945 John J. Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 24 1945, to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Intestinal Obstruction	
Cause Undetermined	11 hrs.
Due to ?	
Due to ?	
Other conditions General Arteriolosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Warren L. Fuller MD

M. D. or other

Address Loch Raven Rd. Baltimore 6 Md Date signed July 24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

06786

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, institution, or street address where death occurred:
Westminster Road
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Westminster Road
(If rural, give LOCATION)
2.(a) If veteran, name war: First World war

3.(a) FULL NAME: Ralph Peary Naylor

3.(b) Social Security Number: 213-09-8518

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Catherine Waters Naylor
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): September 13 - 1892

8. AGE: Years	Months	Days	If less than one day
52	10	18	....hrs. ....min.

9. Birthplace: Horshan Penna (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: -

FATHER
12. Name: John r Naylor
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Kelly
15. Birthplace: England

16. Informant: Catherine Waters Naylor
Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 2-1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Frederick Ave Balto Md
18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. 8-1-45 19.... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 h 19 45, at 2.30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 d 19 41 to death 19 ....
and that I last saw h...m alive on July 26 19 45

Immediate cause of death: Bronchial asthma — DURATION: 10 yrs
Due to: — DURATION:
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Walter Landau M. D.
M. D. or other
Address: Reisterstown, Md. Date signed 8-1-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M. D. B 1268-9

06787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH — Registered No. .....

~~CITY OF~~ BALTIMORE: (No. 5721 Johnson St St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME ~~Edward Hebowski~~ Gunhilde Nilsen.

(a) Residence: No. 5721 Johnson St. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martin

6. DATE OF BIRTH (month, day, year) Sept 9-1865

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	10	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Norway

FATHER

13. NAME Paul Jensen

14. BIRTHPLACE (city or town) (State or country) Norway

MOTHER

15. MAIDEN NAME Bertha Larsen

16. BIRTHPLACE (city or town) (State or country) Norway -

17. INFORMANT Magda Gendelson
(Address) 5071 Johnson St.

18. BURIAL, CREMATION, OR REMOVAL Lutheran Cemetery
Place Burial N.Y. Date 8-4-45 19

19. UNDERTAKER A. Lee Oder
(Address) 4644 York Rd.

20. FILED AUG 1 - 1945 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 31. 1945

22. I HEREBY CERTIFY, That I attended deceased from June 10, 1945 to July 31, 1945

I last saw h... alive on July 31, 1945 Death is said to have occurred on the date stated above, at 6.37 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of the stomach	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
..... If so, specify .....

(Signed) Samuel Ruben, M. D.

(Address) 23 Holaplace

N. B.—WRITE MAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. 3

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel,* etc. For a person who had no occupation whatever write *none.*

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver,* etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill,* etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer,* etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist,* etc. Distinguish carefully between *retail merchants* and *wholesale merchants.* A person who sells goods should be called a *salesman* and not a *clerk.*

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.,* heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M. D. B. 1268-9

06788

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Eutaw Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel O'Donovan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie White
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): October 25, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	6	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Publisher
11. Industry or business: Publishing
FATHER 12. Name: John B. O'Donovan
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Margaret O'Brien
MOTHER 15. Birthplace: Ireland
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1945 (month) (day) (year)
Cemetery or crematory: Mem. Cathedral
Location: Balto. Md.
18. Funeral director: Henry M. Jenkins Sons
Address: 2 E. Fulton & Richard Sts
19. Aug 1 1945 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 45 at 10:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 45 to July 31 19 45 and that I last saw him alive on July 31 19 45

Immediate cause of death	DURATION
Chronic hemorrhagic hypertrophic cystitis	2 mos.
Due to: Chronic benign hypertrophic prostatitis	Indef.
Due to: Chronic arteriosclerotic myocardial disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed 7/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06789 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1337 S. Clinton St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: JOSEPH OMSSEN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Wid.

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): January 24, 1896

8. AGE: Years	Months	Days	If less than one day
49	6	17	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Stevedore

11. Industry or business:

FATHER — 12. Name: James Omssen
13. Birthplace: Norway

MOTHER — 14. Maiden name: Margaret Fick
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/45 (month) (day) (year)

Cemetery or crematory: Mt Carmel Cemetery

Location: O'Donnell St.

18. Funeral director: John F. Duda

Address: 2829 Hudson St.

19. 7/21/45 (Date rec'd by registrar) Registrar: DA Redeed per DA

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6, 1945 to July 19, 1945 and that I last saw him alive on July 19, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv. active	2 Months plus
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., MC, CHIEF OF CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 7-19-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (H) RE

06790 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Facility

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4651 Pimlico Road
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American ✓

3. (a) FULL NAME: ENZOR BERNARD OUSLER

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie E. Ousler

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 31, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	-	3	...hrs. ...min.

9. Birthplace: Hayes, Maryland (Town, county, and state)

10. Usual occupation: Mill worker

11. Industry or business:

FATHER
12. Name: George Ousler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Matilda Dell
15. Birthplace: Maryland

16. Informant: Clinical Records, Veterans Administration, Fort Howard, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-45 (month) (day) (year)

Cemetery or crematory: Oakland Mills M.E. Church

Location: Oakland, Mills, Md.

18. Funeral director: Young Byers

Address: 5005 Park Heights Ave

19. 7/5/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1945, at 2.20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1945, to July 3, 1945 and that I last saw him alive on July 3, 1945

Immediate cause of death: Bronchopneumonia — DURATION: 3 days

Due to: Other conditions: Cerebral arteriosclerosis — Unknown

Due to: Uremia — 3 days

Prostatic hypertrophy — Unknown

Other conditions: Diabetes mellitus — "

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

22. SIGNATURE: A. M. BALTER, LT. COL. M. D. or other

Address: Fort Howard, Md. Date signed: 7/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

84
8
92

Evidence for the change of year of birth is shown on G 99 12-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

06791 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 624 Bye St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Townsend Poole

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	M

6.(b) Name of husband or wife: Daisey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 14 1888 (18)89

8. AGE: Years	Months	Days	If less than one day
56	10	20	hrs. min.

9. Birthplace: Charlotte Court House Va (Town, county, and state)
10. Usual occupation: Crane Operator
11. Industry or business

FATHER
12. Name: Joseph W. Poole
13. Birthplace: Va

MOTHER
14. Maiden name: Fannie Turner
15. Birthplace: Va

16. Informant: Daisey Poole
Address: 624 Bye St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-5-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:

18. Funeral director: Sam'l H. Chase Sons
Address: 638 N. Gilmor St

19. July 2 19 45 (Date rec'd by registrar) A. M. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 45 at 5-50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to July 1 19 45 and that I last saw h... alive on June 29 19 45

Immediate cause of death	DURATION
Chronic Congestive Heart failure	6 wks.
Due to: Hypertension & Cardiovascular Renal disease	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. G. Dewindo M.D. M. D. or other
Address: 520 D St. Sp Pt 19 Date signed 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH ★

06792

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
3 Hillside Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 Hillside Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: **----------

3.(a) FULL NAME: GERTRUDE CHAUNCEY PROCTOR

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frederick R. Proctor
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): September 26, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	10	....hrs. ....min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER
12. Name: William A. Chauncey
13. Birthplace: Harpers Ferry, W. Va.
MOTHER
14. Maiden name: Laura Praether
15. Birthplace: Beltsville, Md.
16. Informant: Frederick R. Proctor
Address: 3 Hillside Ave., Towson Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.
18. Funeral director: John Burns Sons
Address: Towson, Maryland
19. July 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1945 at 2:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that attended deceased from Last '43 to July 6 '45
and that I last saw her alive on July 6. 1945

Immediate cause of death	DURATION
Carcinoma - Cervix	1½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma - Cervix
Biopsy - Date of op. Jan 14 45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John Green M.D.
M. D. or other
Address: Towson Md. Date signed 7/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

06793

CERTIFICATE OF DEATH

★ Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Baltimore
City or town: Phoenix P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
Dances' Mill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Phoenix P.O. (Blenkrim)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dances' Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK CALVIN PYLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Male~~ M	White	Married

6.(b) Name of ~~husband or~~ wife: Ella Lee Pyle
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): February 13, 1869

8. AGE: Years	Months	Days	If less than one day
~~76~~ 76	4	18	___ hrs. ___ min.

9. Birthplace: Chestnut Hill, Harford Co., Md.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Retired

FATHER
12. Name: William Pyle
13. Birthplace: England (?)

MOTHER
14. Maiden name: Esther Pyle
15. Birthplace: England (?)

16. Informant: Roy L. Pyle
Address: Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4, 1945 (month) (day) (year)
Cemetery or crematory: Deer Creek Church Cem.
Location: Chestnut Hill, Harford Co., Md.

18. Funeral director: John Burns' Sons
Address: Towson, Maryland

19. 7/3/45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945 at 6:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 1944 to June 30 1945
and that I last saw h~~im~~ alive on June 30 1945

Immediate cause of death	DURATION
Cardiac Insufficiency	6 mth
Due to: Carcinoma of Pancreas	1 yr
Due to: Colon	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or Coroner
Address: Baldwin Date signed: 7/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

06794

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1005 K. St. Room 70

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: B.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 K. St. Room 70

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME Henry Reel.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 11 - 1882

8. AGE: Years 63 | Months 4 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace: Farmville, Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Bethlehem Steel

FATHER 12. Name: Frank Reel

FATHER 13. Birthplace: Va.

MOTHER 14. Maiden name: Martha Hall

MOTHER 15. Birthplace: Va.

16. Informant: Mary L. Oliver

Address: 707 Avondale Rd. Turner St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 3-45 (month) (day) (year)

Cemetery or crematory: Farmville

Location: Prince Edward Co. Va.

18. Funeral director: Jas. F. Chase & Son

Address: 638 N. Gilmor St.

19. 7/31/45 (Date rec'd by registrar) Alb. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945, to July 30 1945 and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Occlusion

Due to: Cardiac Asthma

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
Some days
Several Years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. L. Laurence M. D. (M. D. or other)

Address: Dundalk Md. Date signed: 11 Aug 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

CERTIFICATE OF DEATH

06795

★ Reg. Dist. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodstock R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Woodstock R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wrights Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Rosella Riley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Edgar Riley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1878

8. AGE: Years	Months	Days	If less than one day
66	10	16	hrs. min.

9. Birthplace: Howard Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: John Dickey
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Laura Gibson
MOTHER — 15. Birthplace: Unknown
16. Informant: William Edgar Riley
Address: Woodstock R. F. D. - Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27 1945 (month) (day) (year)
Cemetery or crematory: Good Shepherd Cem.
Location: Ellicott City Md.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. 7/26/45 (Date rec'd by registrar) 1945 Wm. E. Martus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1945, at 3:15 A.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1945, to July 25, 1945
and that I last saw h.. alive on July 24, 1945

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martus M. D. or other
Address: Randallstown Date signed: 7/26/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

06796

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Baltimore ★ Registration Dist. No. 38

Village or City 227 Hopkins Rd No. Rodgers Forge St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Peter A. Riley

(a) Residence: No. 227 Hopkins Rd St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Gallagher

6. DATE OF BIRTH (month, day, and year) 10/12/1866

7. AGE: Years 78 Months 9 Days 6 If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) ~~Baltimore~~ (State or country) New Jersey

FATHER

13. NAME Michael Riley

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Mr. Joseph Riley (Address) 227 Hopkins Rd.

18. BURIAL, CREMATION, OR REMOVAL Place Cathedral Date 7/21/45, 19

19. UNDERTAKER J. J. Fahey Rodgers Forge (Address) 1308 Liberty St.

20. FILED July 21, 1945 [illegible signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 18 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1945, to July 16, 1945

I last saw h is alive on July 16, 1945; death is said to have occurred on the date stated above, at 4:05 AM.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Haemorrhage	7/2/45
~~Hypert~~	

Other Contributory Causes of importance:

Hypertensive & Arteriosclerotic Cardiovascular Disease	1933

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19__

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) H. Raymond Peters M. D.

(Address) 1127 N Calvert St., Balto-2-Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

06797

CERTIFICATE OF DEATH

★ Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Talbot

City or town Easton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME ROE, Alice

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 23rd 1881

8. AGE:

Years	Months	Days	If less than one day
63	11	14	..... hrs. ..... min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)

10. Usual occupation Nurse.

11. Industry or business

FATHER 12. Name Wm A. Roe

13. Birthplace Md

MOTHER 14. Maiden name Isabell H ——— ?

15. Birthplace Md.

16. Informant Hospital Records

Address Fort Howard Md.

17. Burial (Burial, cremation, or removal) Which?) Date thereof 7/13/1945 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Va.

18. Funeral director A. Lee Oder

Address 4644 York Rd.

19. 7/11/1945 (Date rec'd by registrar)

Nellie Womelson Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945 at 3:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945, to July 7, 1945 and that I last saw her alive on July 7, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	7 Days
Due to Cerebral Arteriosclerosis	plus
Due to	
Due to	

Other conditions Hypertension, Arteriosclerotic heart disease with myocardial failure

Old healed fracture left pubic bone

(Significant conditions contributing to death but not related to immediate cause given in 21)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work? No

23. SIGNATURE Robert M. Culleson Maj. MC. M. D. or other

Address Fort Howard, Md. Date signed 7-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06798 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Harbor View - Balto. 24 - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Harbor View - Balto 24.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 S. 48th St.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: Lydia M. Rose.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: William H.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 3. 1892

8. AGE: Years	Months	Days	If less than one day
53	4	26	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: .....

FATHER
12. Name: William S. Fell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary "
15. Birthplace: "

16. Informant: Mrs McLaughlin
Address: 901 E. 33rd Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/45 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Baltimore Co.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 7/30 19 45 A & W Hiden Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 45, at 5:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma of Cervix	15 mos.
c Generalized Metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M Bowers M.D.
Asst Dir. Med. Exam. Balto. or other
Address: Parkdale Md. Date signed 8-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-a

CERTIFICATE OF DEATH

06799

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: BALTIMORE

City or town: Glenn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Long Green Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Glenarm (If outside city or town limits, write RURAL and give nearest town)

Street No.: Long Green Rd. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John C. Russell

3.(b) Social Security Number: 217-03-1662

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Matilda J. Russell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 15th 1880

8. AGE:

Years	Months	Days	If less than one day
64	9	26	..... hrs. ..... min.

9. Birthplace: Balto Co Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: C Chas. Russell

13. Birthplace: Balto. Co. Md.

MOTHER — 14. Maiden name: Anna E. Schaffer

15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. Eugene Leight

Address: Long Green Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 13 45 (month) (day) (year)

Cemetery or crematory: Waugh Chapel

Location: Balto. Co. Md.

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Rd

19. 7/12/45 (Date rec'd by registrar) W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945, at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1945, to July 11 1945

and that I last saw h.. alive on July 11 1945

Immediate cause of death: Cerebral hemorrhage — DURATION:

Due to: Cerebral [redacted] arteriosclerosis

Due to: Senility

Other conditions: Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George E. Merrill MD (M. D. or other)

Address: Baldwin, Md. Date signed: 7/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

96810

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore County
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month and a half
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Myrtie May Sanborn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Archie Orlo Sanborn
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 1st 1878

8. AGE: Years	Months	Days	If less than one day
67	1	10	...hrs. ...min.

9. Birthplace: Michigan
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:

FATHER
12. Name: William Rathborn
13. Birthplace: Michigan

MOTHER
14. Maiden name: Clarrica Potter
15. Birthplace: Michigan

16. Informant: Archie Orlow Sanborn
Address: 29 Chatsworth Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.

18. Funeral director: J. Arthur Walters By A.M. Duff
Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. 7-12-1945 (Date rec'd by registrar) Dana B. Spine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-23 1945 to July 12 1945 and that I last saw h.er alive on July 11 1945

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs.
Due to	
Due to	
Other conditions: Diabetes	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other
Address: Reisterstown, Md. Date signed: 7-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

06801

★ Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto Co
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7600 North Point Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Rogers Howard SAPP

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24 1945

8. AGE:

Years	Months	Days	If less than one day
	1	24	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Howard Thomas Sapp
13. Birthplace: Grafton W Va

MOTHER
14. Maiden name: Virginia Maria Cook
15. Birthplace: Emmorgad W Va

16. Informant: Mr Howard L Sapp
Address: 7600 N Point Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/30/45 (month) (day) (year)
Cemetery or crematory: Woodsdale Mem
Location: Grafton W Va

18. Funeral director: John F. Henry Inc
Address: 715 Light St

19. July 28 1945 (Date rec'd by registrar) Dawson L. Ruben Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 27 1945 and that I last saw him alive on July 26 1945

Immediate cause of death	DURATION
Congenital Heart Dis	since birth
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C B Winder M.D. M. D. or other
Address: 520 D St. Sp Hg Date signed: 7-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

COMPLETE change of age of deceased: new cer. from Dr. Hudson statement from niece of deceased plus second doctor's statement. Filed 6/7 8-28-45. Permanent file under SCHMALL 8-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (830)

Reg. Dist. No. 40

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Balto.
(b) City or town Kingsville (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 1 mo. 12 days

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Kingsville Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Julia Frances Schmall

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Peter F. Schmall

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 13 1871 ~~Dec. 12, 1871~~

8. AGE: Years 74 | Months 6 | Days 27 | If less than one day ____ hr ____ min.

9. Birthplace Charlestown, S. C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Matheus
13. Birthplace England

MOTHER
14. Maiden Name Mary Schwing
15. Birthplace Germany

16 (a) Informant Mrs. D. Kopp
(b) Address Kingsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14-45 (month) (day) (year)
(c) Cemetery or crematory Sherman Cem.
Location Sherman P.O.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) July 10-45 (Date rec'd by registrar) (b) Clarence E. Arthur Deputy Registrar

MEDICAL CERTIFICATION

20. Date of death July 9 1945, at 8:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 July 1945, to 9 July 1945 and that I last saw him alive on 9 July 1945.

Immediate cause of death	Duration
Cerebral Hemmhage	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifford F. Hudson M.D. (M. D. or other)
Address Fork Md Date signed 7/9/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93) Bc

06803

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Baltimore

City or town Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days 4 hrs.

Hospital, institution, or street address where death occurred:

Relay Sanitarium

How long in hospital or institution? 5 days 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3405 Elgin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cosoma Serio

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Frances

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1884

8. AGE: Years 61 | Months 1 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Shop owner

11. Industry or business

FATHER 12. Name Joseph Serio

13. Birthplace Italy

MOTHER 14. Maiden name Rosie De Marco

15. Birthplace Italy

16. Informant Dr D[illegible]o Salvatore Serio

Address 3405 Elgin Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/45 (month) (day) (year)

Cemetery or crematory N. Cathedral

Location Frederick Rd.

18. Funeral director M. W. E. Dippel's Sons

Address Broadway & Aisquith St.

19. 7/7 45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5 1945, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/30 1945, to 7/5 1945 and that I last saw h[illegible] alive on 7/5 1945

Immediate cause of death	DURATION
Cardio respiratory failure	
Due to Chronic myocardial	
Heart disease	
Due to	
Other conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cliff Rawitt J. M.D. M. D. or other

Address 4 Cypress Road Date signed 7/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

'41
61
84

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Dist. No. 068043

1. PLACE OF DEATH:

County: Baltimore

City or town: Villa Nova
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Villa Nova
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rockridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ida Bertha Shearer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Lawson B. Shearer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 20 1870

8. AGE: Years	Months	Days	If less than one day
75	4	15	hrs. min.

9. Birthplace: Parkersburg W.Va.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Switzerland

16. Informant: Alan F. Fitzpatrick

Address: Rockridge Road Villa Nova

17. Burial — Date thereof: July 7 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md

18. Funeral director: Harry T. Amacost

Address: 4204 Ridgewood Ave

19. 7/6 45 — Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5th 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to July 5th 1945, and that I last saw h.e.r. alive on July 4th 1945.

	DURATION
Immediate cause of death: Pulmonary Oedema	24 hrs
Due to: Acute Cardiac Dilatation	2-3 days
Due to: Chronic Mitral Endocarditis & Myocarditis	unknown
Other conditions: Chronic Nephritis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: C. A. Enson M.D.

Address: 720 York Rd. Balto 12. Md. M. D. or other

Date signed: 7-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

86805 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Baltimore
County ....
City or town Sp. Pt. -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ....
Hospital, institution, or street address where death occurred: ....
How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County ....
City or town Sparrows Pt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 S Wolfe St
(If rural, give LOCATION)
2.(a) If veteran, name war ....

3. (a) FULL NAME Charles Howard Shiflett

3. (b) Social Security Number ....

4. Sex M.

5. Color or race W.

6. (a) Single, married, widowed, or divorced ....

6. (b) Name of husband or wife ....
6. (c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Nov. 13 - 1890

8. AGE: Years 54 Months 8 Days 9 If less than one day .... hrs. .... min.

9. Birthplace Charlottsville Va
(Town, county, and state)

10. Usual occupation Mill Wright

11. Industry or business Sparrows Pt.

FATHER
12. Name Charles H Shiflett
13. Birthplace Va

MOTHER
14. Maiden name Sarah Wald
15. Birthplace Va

16. Informant Russell H. Shiflett (Bro.)
Address 204 C Street Sparrows Pt.

17. Burial Date thereof 7/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Charlottsvill
Location Virginia

18. Funeral director Lilly & Zeiler Co
Address 403 S. Wolfe St

19. 7/27 19 45 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 9⁰⁵ a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19.........., to .... 19..........
and that I last saw h.... alive on .... 19..........

Immediate cause of death Cerebral Hemorrhage — DURATION 2 hrs.
Due to ....
Due to ....
Other conditions ....
(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work? ....

23. SIGNATURE W. B. Davis M.D. M.D. or other
Asst. Med. Exam - Balto Co
Address Dundalk Md Date signed 7-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06806

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
812 Wilson Pt. Rd.

How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 Wilson Pt. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Horace Wilson Shuster

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Emma Cecelia Shuster

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15, 1862

8. AGE: Years	Months	Days	If less than one day
83	0	21	..... hrs. ..... min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business

FATHER
12. Name: Johathan Shuster
13. Birthplace: Pa.

MOTHER
14. Maiden name: Hannah Macconahey
15. Birthplace: U. S.

16. Informant: Oliver H. Bair Co.

Address: Philadelphia, Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/7/45 (month) (day) (year)

Cemetery or crematory

Location: Phila., Pa.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 7/7 1945 City Health Dept. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1945 at 10 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to July 6 1945 and that I last saw h... alive on July 6 1945

Immediate cause of death	DURATION
Bilateral Broncho Pneumonia	1 day.
Due to	
Due to	
Other conditions: Arteriosclerotic Heart Disease	10 yrs
Spastic Colitis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John C Bair M D
M. D. or other

Address 815 Eastern Av. Balto 24 Date signed July 7 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-4)

CERTIFICATE OF DEATH

06807

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 708 Meadowbrook Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas William Simons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Katherine Dimler Simons
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1869

8. AGE:

Years	Months	Days	If less than one day
75	7	3	hrs. min.

9. Birthplace: Harpers Ferry, Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Parents
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ellen Duet
15. Birthplace: Maryland

16. Informant: Joseph H. Simons
Address: 583 Frederick Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30, 1945 (month) (day) (year)
Cemetery or crematory: Salem Lutheran
Location: Catonsville, Md.
18. Funeral director: Easton Sons
Address: 608 Frederick Ave. Catonsville
19. July 29th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-27 1945 at 5-00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-25 1945, to 7-27 1945 and that I last saw h... alive on 7-27 1945.

Immediate cause of death	DURATION
Coronary thrombosis	48 hrs.
Due to: Auricular fibrillation	2 yrs?
Due to: Renal Disease	4 yrs?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Edgar E. Urban M.D. M. D. or other
Address: 803 Dale Ave. Catonsville 28 Md. Date signed: 7-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

CERTIFICATE OF DEATH

16808 P

Reg. Diat. No. 41

1. PLACE OF DEATH:

County Balto.

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1739 Leslie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1739 Leslie Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HERMAN SKINNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1885

8. AGE: Years	Months	Days	If less than one day
60	0	16	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Labor Boss

11. Industry or business Park Board

FATHER
12. Name Cornelious Skinner
13. Birthplace Va.

MOTHER
14. Maiden name Laura Herold
15. Birthplace Balto., Md.

16. Informant Mrs. Nettie H. Snyder
Address 2416 Linden Ave.

17. Burial Date thereof 7/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18. Funeral director Wm. J. Tickner & Sons
Address Balto., Md.

19. 7/24 19 45 C W Kedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945 to July 22 1945
and that I last saw him alive on July 22 1945

Immediate cause of death	DURATION
Carcinoma of Cardia	
and of Stomach	June 2/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations as above. Date of op. June 24/45

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Schumacher M.D.
M. D. or other

Address 642 S. Eutaw Date signed 7-29-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reed vs
7/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06809

★ Reg. Dist. No. 35

1. PLACE OF DEATH:

County Baltimore

City or town White Hall, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town White Hall Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Josiah Leonard Slade

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Mary B. Slade

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6. 1873

8. AGE:

Years	Months	Days	If less than one day
72	1	25	..... hrs. ..... min.

9. Birthplace White Hall (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Christopher Slade

FATHER 13. Birthplace White Hall.

MOTHER 14. Maiden name Elizabeth Carlin

MOTHER 15. Birthplace White Hall

16. Informant Mrs. Stanley Slade

Address White Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3-1945 (month) (day) (year)

Cemetery or crematory Vernon

Location White Hall, Md

18. Funeral director Howard S. Mathias

Address White Hall. Md

19. Aug 1 1945 (Date rec'd by registrar) Mrs Howard S. Mathias Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 7.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to July 31 1945

and that I last saw him alive on July 31 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions Senility, generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. M. France M. D. or other

Address Parkton, Md Date signed 8/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

6810 P

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Balto.

City or town: Rapeharry T. O. 6.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 4230 Cardwell ave.

How long in hospital or institution? 5 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Rapeharry P.O. 6

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4230 Cardwell ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Verge Wills Sprouse.

3.(b) Social Security Number: 217-07-6287

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Lillian Tyral

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 11/1891

8. AGE: Years: 53 | Months: 9 | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Orange Co. Va.

(Town, county, and state)

10. Usual occupation: Carpenter.

11. Industry or business: Henry C. Roytan.

FATHER — 12. Name: Benj. Sprouse

13. Birthplace: Va.

MOTHER — 14. Maiden name: Camilla Napier.

15. Birthplace: Va.

16. Informant: Mrs. Lillian March Sprouse

Address: 4230 Cardwell ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/6/45 (month) (day) (year)

Cemetery or crematory: Forest Hill

Location: Louisa Louisa County Virginia

18. Funeral director: George D. Ruth Inc.

Address: 1735 Hilford Ave

19. 7/3/45 (Date rec'd by registrar) 19..... H. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1945, at 6A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	3 min.
Due to: Pleurisy & Pneumonia	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Learmonth M.D. Deputy medical examiner M. D. or other

Address: Rockbridge Mo Date signed 7/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

06811

CERTIFICATE OF DEATH ★

Reg. Diat. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville, Colonial Village
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7021 Plymouth Rd
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Catherine M. Steinmetz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Francis George Steinmetz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 12 - 1856

8. AGE: Years	Months	Days	If less than one day
89	6	8	..... hrs. ..... min.

9. Birthplace Gettysburg Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Staub
13. Birthplace Alsace Lorraine, France
MOTHER 14. Maiden name Catherine Cordari
15. Birthplace France
16. Informant Otto George Steinmetz
Address 7021 Plymouth Rd. Pikesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23-45 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md
19. Funeral director Frank H. Meyerl
Address Pikesville, Maryland.
19. 7-21-1945 (Date rec'd by registrar) Dr. E.E. Nichols MW. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 6.18 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943, to July 20 1945 and that I last saw her alive on July 19 1945
Immediate cause of death Carcinoma of Stomach
Due to Arteriosclerosis
Due to .....
Other conditions Senility
(Include pregnancy within 3 months of death)
Major findings of operations No operation Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION
2 yrs

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E.E. Nichols M.D.
M. D. or other
Address Pikesville 8, Md. Date signed 7/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (43a)

Registered No. [redacted] 46813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Balto. Co.
(a) Baltimore City, Maryland Catonsville
(b) Street address 313 EDMONDSON AVE
(c) Hospital or institution: Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALTO. - RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. ENGLISH COUNCIL MD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE STRAUSS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Adolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 Months Days If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry of business

FATHER 12. Name John

13. Birthplace Russia

MOTHER 14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Walter Strauss

(b) Address 1116 W. Balto St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)

(c) Cemetery or crematory Washington Blvd

Location Washington Blvd.

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100-02 EUTAW PLACE

19 AUG 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31/45 19 ..., at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 45, to July 19 45, and that I last saw h[illegible] alive on July 1 19 45.

	Duration
Immediate cause of death Exhaustion	
Due to Carcinoma of Cervix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/22/45 - 7/24/45

Major findings of operation: [illegible]

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 7/31/45 M. D.

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

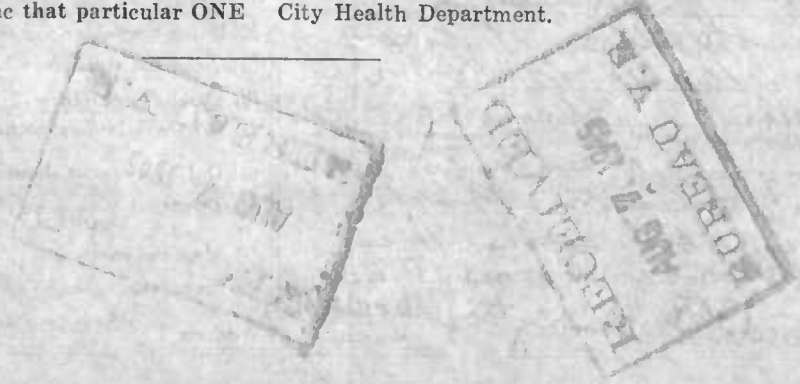
If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [redacted]

06814

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Co.
(b) Street address 648 Orpington Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 Orpington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Stumpf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8/1867

8. AGE: Years 78 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George M. Stumpf

13. Birthplace Md

MOTHER 14. Maiden Name Mary —

15. Birthplace Md

16 (a) Informant Mrs Ada Dietz
(b) Address 648 Orpington Rd.

17 (a) Burial (b) Date thereof 7, 26, 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Av.

19 (a) JUL 25 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1935, to 7-23 1945, and that I last saw h— alive on 7/23 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Cardio Vascular Renal Disease	10 yr
Due to	

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Lankford M. D.

Address 679 Washington Blvd Date signed 7/23/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline **that particular ONE cause** to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the **risk of dying**, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

06815

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: 43 Delrey Ave. – Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 43 Delrey Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CAROLINE (CARRIE) SULLIVAN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wyndham A. Sullivan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 7, 1851

8. AGE: Years	Months	Days	If less than one day
93	7	14	..... hrs. ..... min.

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William Braunline

13. Birthplace: Germany

MOTHER — 14. Maiden name: Marie Englehardt

15. Birthplace: Germany

16. Informant: Miss Martha King

Address: 43 Delrey Ave., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 7/16 19 45 (Date rec'd by registrar) N. L. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 19 45, at 12:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 45 to July 14 19 45, and that I last saw h[illegible] alive on July 13 19 45

Immediate cause of death	DURATION
Terminal Hypostasis Pneumonia	2 days
Due to: Chronic Mucous Colitis	6 weeks
Due to:	
Other conditions: Cardiac Vascular Disease & Hypertension (Include pregnancy within 3 months of death)	10 years

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Elliot W. Thurston M 4 M. D. or other

Address: 3432 Frederick Ave. Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06816

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 39 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 138 W. Camden St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: GEORGE W. SULLIVAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-22-95

8. AGE: Years	Months	Days	If less than one day
50	5	2	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Washington Sullivan

13. Birthplace: Prince George, Md.

MOTHER — 14. Maiden name: Forey Carek

15. Birthplace: Savage, Md.

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-28-45 (month) (day) (year)

Cemetery or crematory: Balto. National

Location: Baltimore, Md.

18. Funeral director: W. Howard Strong

Address: 3207 W. North Ave.

19. 7/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1945 19 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1945 19 to July 24, 1945 19 and that I last saw him alive on July 24, 1945 19

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv.	3 Mos. plus
Due to:	
Due to:	
Other conditions: Asthma bronchial	
Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? No

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT.COL., M.C. M.D. Recorder.

Address: Ft. Howard, Md. Date signed: 7-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of usual residence of deceased is shown on FILM No. G 97 JUL 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06817

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baelo Co

City or town: Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years.

Hospital, institution, or street address where death occurred: #3 arthur ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: #3 Arthur Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edgar Matthew Taylor.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married.

6.(b) Name of husband or wife: Mary E Taylor.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 13. 1892

8. AGE: Years	Months	Days	If less than one day
63.			hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Pressman.

11. Industry or business: Newspaper.

FATHER — 12. Name: Edgar M. Taylor Sr.

FATHER — 13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Laudonia Smith

MOTHER — 15. Birthplace: Maryland.

16. Informant: Mary E Taylor

Address: #3 Arthur ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13/1945 (month) (day) (year)

Cemetery or crematory: Nat National

Location: Baelo Md.

18. Funeral director: Edw S Mac Nabb

Address: Catonsville Md.

19. 7/13/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945, at 1-45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1945 to July 10 1945 and that I last saw him alive on July 10 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	10 days
Due to: Hypertension	10 yrs.
Due to:	
Other conditions: Chr. Glomerulonephritis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A M Fleming M. D. M. D. or other

Address: Catonsville Md. Date signed: 7/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

CERTIFICATE OF DEATH

06818

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1325 Webster Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Howard Thomas (Thomas Howard)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White.	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE:	Years	Months	Days	If less than one day
	58	?	?	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER 12. Name: Samuel Thomas

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: Virginia ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Ave.

18. Funeral director: John F. Denny Inc

Address: 745 Light St.

19. 7/17 19 45 W. C. Andrae Deputy Local Registrar (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 19 45 at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 45 to July 17 19 45 and that I last saw him alive on July 17 19 45

Immediate cause of death	DURATION
Pulmonary oedema	4 hours
Due to: Uraemia	Indef.
Due to: Acute exacerbation, chronic myocardial insufficiency	"
Other conditions: Chronic glomerular nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville, Balto.-28, Md. Date signed 7/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 44

06819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Balto 19

(If outside city or town limits, write RURAL and give nearest town)

Street No. 832. N. Howard St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JEAN TICE (GENE HOWELL)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married ?

6.(b) Name of husband or wife: John Howell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2nd 1922

8. AGE:

Years	Months	Days	If less than one day
23	3	4	hrs. min.

9. Birthplace: Lewisburg, W. Va.

(Town, county, and state)

10. Usual occupation: Riveter

11. Industry or business

FATHER

12. Name: Charles Moody

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Millie Crone

15. Birthplace: W. Va.

18. Informant: Mrs. Millie Moody (Mother)

Address: Ronceverte, W. Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/9/45 (month) (day) (year)

Cemetery or crematory:

Location: Lewisburg West Va.

18. Funeral director: John J. Donnelly

Address: 48 Carstens Ave.

19. 7/9/ 19 45 (Date rec'd by registrar) J. Donnelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 19 45, at 10 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7-6-45

Where did injury occur? Dundalk (City or town) Balto (County) Md (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Drowning Injured at work? No

23. SIGNATURE: M D Davis M.D.

Asst Supt. Med. Exam. (M.D. or other)

Address: Dundalk Md Date signed 7-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

06820

Reg. Dist. No. 44

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, Institution, or street address where death occurred:
U. S. Veterans Administration

How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

None

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Woodlawn Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1 ✓

3.(a) FULL NAME: Nellie Marie Todd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1891

8. AGE: Years: 53 | Months: ~~6~~ 10 | Days: ~~29~~ 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Todd
13. Birthplace: Frederick, Md.

MOTHER — 14. Maiden name: Melles Stuart
15. Birthplace: Ohio

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-45 (month) (day) (year)

Cemetery ~~or crematory~~: Loudon Park

Location: 3801 Frederick Ave., Balto., Md.

18. Funeral director: John A. Mitchell & Sons Inc.

Address: 1900 Eutaw Place.

19. 7/23 (Date rec'd by registrar) 19 45 G W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-21 19 45, at 7:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-7 19 45, to 7-21 19 45 and that I last saw her alive on 7-21 19 45

Immediate cause of death	DURATION
Carcinoma of cervix and cerebral metastases	6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: I. L. Ochs, Maj. M.C.

Address: Fort Howard, Md. M. D. or other

Date signed: 7-21-45

Rec'd
7/23/45
V.S.

06821 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Bloomsbury Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Tully

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Wm. E. Tulley
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Nov. 23-1862

8. AGE: Years 82 | Months 7 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Charles Raflinski
13. Birthplace Md
MOTHER 14. Maiden name Susan Johnson
15. Birthplace Md
16. Informant Mrs. Edna Southcomb
Address Washington DC.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3-45 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md
18. Funeral director Geo. L. Beyer Jr
Address 1512 Hollins St
19. 7/2 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 8 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18 1944 to July 1 1945
and that I last saw h alive on June 30 1945

Immediate cause of death	DURATION
Cardiac Decompensation	2wk.
Due to Hypertensive Cardio-Vascular-Renal Disease	15yr (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wilmer K. Galloway M.D. M. D. or other
Address Catonsville-28, Md Date signed 7-1-45

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06822

★ Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto Co

City or town Catonsville 2nd.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

St Marys Ind

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. St Marys Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma Manoe Cora Vaughan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

8.(b) Name of husband or wife John T Vaughan

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18 1890

8. AGE:

Years	Months	Days	If less than one day
55			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER

12. Name Marcus L Chaney Jr.

13. Birthplace Maryland

MOTHER

14. Maiden name Katherine H Stuart

15. Birthplace Maryland

16. Informant Mrs Arthur N Pruitt

Address St Marys Ave Catonsville

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 17 45 (month) (day) (year)

Cemetery or crematory Edward Chapel

Location Balto Co Md.

18. Funeral director Edw S Mac Nabb

Address Catonsville Md.

19. 7/16 19 45 (Date rec'd by registrar) F. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 45 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Acute Cardiac failure	
Due to Bronchopneumonia	
Due to	
Other conditions sudden death	
(Include pregnancy within 3 months of death) Injury	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Kieffer Deputized Edgar H Bell M. D. or other

Address 1010 Leadenhall Date signed 7-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06823

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto. City

City or town: Baltimore - 9

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2105 Carterdale Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Latrobe
Eleanor Vinton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife: — — —

8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 7, 1879

8. AGE: Years	Months	Days	If less than one day
66	1	25	____ hrs. ____ min.

9. Birthplace: Boston, Massachussetts
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Hammond Vinton
13. Birthplace: Watertown, New York

MOTHER
14. Maiden name: Marie Eleanor Latrobe
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records

Address: Catonsville, Balto., -28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July - 5 - 1945 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Greenmount Ave., Balto. City

18. Funeral director: Stewart & Mowen Company

Address: 108 W. North Ave. Balto. City, Md.

19. 7/3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1945 at 11:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to July 2 1945 and that I last saw h... alive on July 2 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	3 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville, Balto.-28, Md. Date signed 7/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown on

FILE No. G 97 AUG 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

D6824 P

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, Institution, or street address where death occurred: 65 Burkleigh Road

How long in hospital or Institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 65 Burkleigh Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: Alice Josephine Waldenberger

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Louis Waldenberger

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): October 10, ~~1880~~ ~~1880~~ 1879

8. AGE: Years	Months	Days	If less than one day
65	9	16	-- hrs. --- min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -----

FATHER

12. Name: Henry McKitterick

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Finnegan

15. Birthplace: Ireland

18. Informant: Mrs. Clarence W. Collison

Address: 65 Burkleigh Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Texas, Md.

18. Funeral director: H. W. Meeks and Son

Address: 805 N. Calvert Street

19. July 27 19 45 (Date rec'd by registrar) A. W. Hedrick per A. E. M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 19 45, at 2 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 34, to July 26, 19 45; and that I last saw h-r alive on July 25 19 45.

	DURATION
Immediate cause of death: Heart disease, coronary thrombosis	10 days
Due to: Myocarditis, acute	4/16/45
Due to: Arteriosclerosis	Unk.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rollin B. Hudson M.D. M. D. or other

Address: Towson 4, Md. Date signed 7/26/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06825

Reg. Dist. No. 38

1. PLACE OF DEATH: Balto

County Towson

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes Watson

3. (b) Social Security Number

4. Sex F | 5. Color or race W | b.(=) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Wm Watson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 21 1872

8. AGE: Years 73 | Months 5 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Towson Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Geo H Stieber

13. Birthplace Germany

MOTHER 14. Maiden name Anna Baker

15. Birthplace Germany

16. Informant Mrs Raymond Gaston

Address 406 Central Ave Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21-1945 (month) (day) (year)

Cemetery or crematory Prospect Hill (Towson)

Location Towson Md

18. Funeral director John Burns Sons

Address 610 York Road Towson

19. July 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1944 to July 18 1945

and that I last saw h-er alive on July 18 1945

Immediate cause of death	DURATION
Coronary Occlusion	2 hours
Due to Arterio Sclerotic Heart Disease	yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hunt Kelly M. D. or other

Address Towson Md Date signed 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 35 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1203 Ashland Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WILLIAM WHITFIELD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Virginia Whitfield

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE:	Years	Months	Days	If less than one day
	49			hrs. min.

9. Birthplace: Kingston, N. C.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Louis Whitfield
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Stella Canada
15. Birthplace: North Carolina

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-23-45 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Frederick Ave -

18. Funeral director: A Lee Cober

Address: 4644 York Rd.

19. 7/24 (Date rec'd by registrar) 19 45 C W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945 19 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1945 to July 19, 1945 and that I last saw him alive on July 19, 1945 19

	DURATION
Immediate cause of death: Tuberculosis, chr. pul. far. adv. active	3 Months plus
Due to:	
Due to:	
Other conditions: Anemia, secondary	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? No

23. SIGNATURE: A M Balter
A.M. BALTER, LT. COL., M.C. M. D. CLIN. DIR.

Address: Ft. Howard, Md. Date signed: 7-19-45

Rec'd VS
7/24/

STATE OF MARYLAND—CERTIFICATE OF DEATH

16827

1. PLACE OF DEATH

County Baltimore Co. Registration Dist. No. 38

Village or City Baltimore Co. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Louiser young

(a) Residence: No. 357 Edwood Ave St. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
Female	Col	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Young

6. DATE OF BIRTH (month, day, and year) August 4, 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House Work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Montgomery Co

FATHER

13. NAME Jos Dasbrow

14. BIRTHPLACE (city or town) (State or country) md

MOTHER

15. MAIDEN NAME Eliza

16. BIRTHPLACE (city or town) (State or country) md

17. INFORMANT Martha Banks

(Address) 357 Edwood ave

18. BURIAL, CREMATION, OR REMOVAL

Place Greenmount Date July 9, 1945

19. UNDERTAKER Robert E. Lynch

(Address) Rockville Md

20. FILED July 6, 1945 Alfred Watkins Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 6th (Day), 1945 (Year)

22. I HEREBY CERTIFY That I attended deceased from July 5th, 1945, to July 6th, 1945

last saw h alive on July 6th, 1945; death is said to have occurred on the date stated above, at 9.21 m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	July 5th
Rt. Side (Hemiplegia)	
Other **Contributory Causes** of importance:	
General arterio Sclerosis	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Daniel J. St. Thomas M. D.

(Address) Derwood Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN